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**Examining Racial and Ethnic Differences in the Relationship between Early Life
Conditions and Health in Later Life among Men**

Taylor W. Hargrove
Vanderbilt University

*This study was supported in part by grant No. 68146 from the Robert Wood Johnson Foundation Center for Health Policy at Meharry Medical College. The content is solely the responsibility of the author and does not necessarily represent the official views of RWJF. Address all correspondence to: [Taylor W. Hargrove, Vanderbilt University, Department of Sociology, email: taylor.w.hargrove@vanderbilt.edu]

Introduction

There has been a recent surge of interest in the population health literature in taking a life course approach to understanding health in adulthood. Several studies have demonstrated a relationship between life conditions in childhood and health in later life (Elo and Preston 1992; Haas 2008; Hayward and Gorman 2004; Hamil-Luker and O’Rand 2007; O’Rand and Hamil-Luker 2005). Two main theories connecting early life conditions and adult health have been proposed: biological imprinting and the accumulation of risk theory. Biological imprinting (or the latency model) suggests that exposures in childhood can lead to changes in biological and behavioral systems in ways that make individuals more susceptible to poor health later in life (Halfon and Hochstein 2002; Hertzman 1999). Conversely, the accumulation of risk theory, also referred to as the pathway model, posits that childhood circumstances place individuals on varying social, economic, psychological, and behaviors trajectories that, in turn, may influence health. Early socioeconomic disadvantage, for example, may program a sequence of negative exposures that lead to morbidity and mortality (Hayward and Gorman 2004; Warner and Hayward 2006). It is important to note that these explanations are not competing, but rather may work together in complex ways to shape health (Hamil-Luker and O’Rand 2007).

Though previous research has examined the link between childhood conditions and adult health, less is known about racial and ethnic differences in the significance of such early life conditions for health in adulthood, particularly among men. More specifically, the extent to which early life conditions predict health in later life for blacks and Latinos has not been systematically investigated. Furthermore, a focus on race without a consideration of the role of other socially constructed statuses (e.g., gender) in shaping health ignores a central tenant of sociology: that life chances are shaped by a constellation of social factors (Weber 1946 [1922]). An intersectionality approach to the study of health argues that the meaning and consequences of race and ethnicity depends on other social categories, such as gender and age (Courtenay 2002; Griffith 2012). These social statuses are both simultaneous and interactive, combining in unique ways to shape health. Though most intersectionality studies on health tend to emphasize the disadvantages of women of color (e.g., Ailshire and House 2011; Hinze, Lin, and Andersson 2012; Warner and Brown 2011), it is important to also consider the unique disadvantages of men of color. In particular, black and Mexican American men face a number of unique gendered social norms and cultural expectations that, along with SES and age, may negatively shape their behaviors and health (DuBois 1899; Jackson and Williams 2006; Williams 2003). Compounding these gendered norms and expectations is the stress associated with trying to demonstrate hegemonic masculinity and achieve normative gender expectations (e.g., the traditional role of economic provider for their families) in spite of their limited economic opportunities and exposure to racism (Courtenay 2000; Griffith et al. 2013). These phenomena result in black and Mexican American men being the most disadvantaged across several domains, including incarceration, unemployment, and homicide (Pettit 2012). These disadvantages contribute to disproportionately high rates of unhealthy behaviors and premature mortality among men of color relative to other gender-racial/ethnic groups (Courtenay 2000; Jackson and Williams 2006; Williams 2003).

In this study, I combine intersectionality and life course approaches to explore racial and ethnic differences in the relationship between early life conditions and health in mid- to late-life among non-Hispanic white, non-Hispanic black, and Mexican American men. I examine the consequences of childhood conditions for three health outcomes: self-rated health, functional limitations, and chronic conditions. Additionally, I consider a wider array of childhood

experiences than are typically examined. These multiple measures of childhood experiences provide a more comprehensive picture of early life circumstances.

Data and Methods

Sample

I utilize data from Waves 1-7 of the Health and Retirement Study (HRS) to address the research questions in this study. The HRS is a nationally representative longitudinal panel study, targeting community-dwelling English or Spanish-speaking adults in the contiguous United States over age 50 (spouses of respondents were interviewed regardless of age-eligibility). Blacks and Hispanics were oversampled to allow for independent analysis of racial groups. Respondents were interviewed biennially between 1992 and 2010 (response rates were 82% – 89%). The five cohorts considered in this study were first interviewed in 1992, 1998, and 2004. Levels of poor health may be somewhat understated given the exclusion of institutionalized populations at baseline (though this population consisted of only a minor proportion of individuals). Given the relatively small numbers of non-Mexican Hispanics in the HRS, and the fact that Hispanic subgroups have different health profiles (Markides et al. 2007), Mexican Americans were the only Hispanics included in this study. All racial groups other than blacks and whites were also excluded due to small sample sizes. Thus, the final analytic sample includes 5388 white men, 809 black men, and 642 Mexican American men.

Dependent Variables¹

Self-rated health was measured by respondents' answers to the question, "In general, would you say your health is: excellent, very good, good, fair, or poor?" in Wave 7 of the survey; responses ranged from 1 (excellent) to 5 (poor). Self-rated health is a reliable and valid measure of general health status. In addition, self-rated health is predictive of morbidity (Ferraro, Farmer, and Wybraniec 1997), disability (Idler and Kasl 1995), and mortality (Idler and Benyamini 1997), and has similar predictive validity for mortality and objective health measures across racial/ethnic and gender subgroups (Johnson and Wolinsky 1994; Kimbro, Gorman, and Schachter 2012).

Functional limitations were determined by respondents' difficulty in performing a set of tasks, such as walking several blocks, walking one block, walking across the room, sitting for two hours, getting up from a chair after having sat for a while, climbing several flights of stairs, climbing a single flight of stairs, stooping, kneeling, or crouching, lifting or carrying 10 lbs, picking up a dime off of a table, raising one's arms above one's shoulders, and pushing or pulling large objects such as furniture. I employed a summary measure of the total number of limitations, ranging from 0-12 ($\alpha=.87$).

Chronic conditions were assessed with a summary measure of the total number of chronic conditions ever diagnosed by a physician (range=0-5). Five conditions in total were considered: heart disease, hypertension, diabetes, stroke, and cancer. An index, opposed to single diseases, was used for a variety of reasons. An index better captures the multifaceted nature of health and the broad health consequences of social statuses than an indicator of a single disease (Aneshensel 2005), it provides a more parsimonious approach than analyzing single items (Farmer and Ferraro 2005), it is less likely than binary measures to produce issues around

¹ All outcomes were taken from Wave 7 (collected in 2004) of the HRS so that all five birth cohorts could be included in the analyses.

insufficient statistical power (Ferraro and Wilmoth 2000), and it has better predictive validity for health than general medical examinations, especially among minorities (Ferraro and Su 2000).

Independent Variables

Covariates. The predictors of interest are childhood experiences. Eight early life conditions were considered in this study. Respondents were asked the highest grade of schooling each parent completed. *Mother's education* and *father's education* measured whether the respondents mother and father completed 12 years or more of schooling (yes=1) or less than 12 years of schooling. Respondents were also asked about their families' socioeconomic circumstances and living arrangements before the age of 16. These circumstances and arrangements are indexed by a variety of binary variables: whether the respondent *grew up in poverty* (yes=1), whether the respondent or his family *ever had to move due to financial difficulties* (yes=1), whether there was a time when the respondent or his family *received help from relatives because of financial difficulties* (yes=1), whether the respondent's *father had no job* for several months or more (yes=1), if the respondent *never lived with his father* (yes=1), whether the respondent's *father had a white collar job* when the respondent was 16 years old (1=yes), and whether the respondent *ever lived with his grandparents* (yes=1).

Adult SES. Several adult SES measures were also taken into account to examine whether circumstances in adulthood mediated the link between childhood experiences and health in later life. *Educational attainment* was measured in years of schooling (0-17), *household income* was assessed with a logged measure of all wages and salaries from individuals in the household, and *wealth* was measured by logged net worth (total assets – total liabilities). All adult SES measures were collected in 2004 (Wave 7).

Controls. A number of sociodemographic characteristics were taken into account. Binary variables indexed self-reported race/ethnicity: non-Hispanic whites (yes=1), non-Hispanic black (yes=1), and Mexican American (yes=1). Only US-born whites and blacks were considered, and all analyses for Mexican Americans controlled for nativity (foreign born=1) given the well-documented immigrant health advantage (Markides et al. 2007). Age and marital status (married/partnered=1) in 2004 were also included in the analysis. Furthermore, health in childhood was controlled for in order to account for the effect of early health on health in later life. Childhood health was measured with the question, "Consider your health while you were growing up, from birth to age 16. Would you say that your health during that time was excellent, very good, good, fair, or poor?" Responses ranged from 1 (excellent) to 5 (poor).

In order to avoid confounding age-related changes with cohort differences, analyses controlled *birth cohorts* (Brown O'Rand, and Adkins 2012; Yang and Lee 2009). Members of the AHEAD birth cohort, who serves as the reference group, were born before 1924. Other cohorts were born from 1924-1930 (CODA cohort), 1931-1941 (HRS cohort), 1942-1947 (War Baby cohort), and 1948-1953 (Early Baby Boomer cohort). Additionally, to control for differential rates of response to early life measures, binary variables of whether respondents were missing on each childhood condition were included. Finally, to partially account for measurement error in the evaluation of serious illnesses among respondents with limited access to care, all estimates of chronic conditions controlled for whether respondents had private health insurance. For the sake of concision, coefficients for the control variables are not presented (available upon request).

Analytic Strategy

Weighted least squares regressions were used to investigate the relationship between early life conditions and health in adulthood among white, black, and Mexican American men. All models were stratified by race/ethnicity. All analyses are conducted using Stata version 11.2.

Results

Self-Rated Health (Table 1)

Among whites, several early life conditions significantly predict self-rated health, including mother and father's education and whether the respondent's father had a white-collar job. Higher parental education and having a father with a white-collar job are associated with better reports of health. Parental education remains significant when controlling for adult SES, though their effects are reduced by about 50%. All adult SES measures predict self-rated health for white men: more years of schooling, household income, and wealth are associated with better reports of health.

Among black men, however, no early life conditions significantly predict self-rated health. Only adult SES measures are associated with self-rated health in adulthood. Higher levels of educational attainment, household income, and wealth all significantly predict better reports of health.

Among Mexican American men, father's education significantly predicts self-rated health in adulthood, with higher paternal education being associated with better reports of health. This effect of father's education, however, is explained by the respondent's educational attainment and household income. More years of schooling and higher levels of household income predict better reports of health.

Overall, these findings suggest partial support for the latency model and the pathway model for white men. Early life conditions continue to impact adult health even when adjusting for adult SES (supporting the imprint hypothesis) and adult SES, in addition to childhood SES, influence health in later life (supporting the accumulation of risk hypothesis). For black men, however, there are only proximate effects of SES on adult health. Lastly, there is only partial support for the pathway model among Mexican American men.

Functional Limitations (Table 2)

Similar to self-rated health, mother and father's education, as well as whether the respondent's father had a white-collar job, are significantly associated with functional limitations in mid- to late-life for white men. Having parents with a high school diploma or higher and having a father who had a white-collar job reduces the amount of functional limitations in adulthood. Additionally, whether the respondent or his family moved in his childhood due to financial difficulties significantly predicts more functional limitations in adulthood. Father's education and whether the respondent or his family moved due to financial difficulties remain significant even when controlling for adult SES, though their effects are reduced by about 40% and 20%, respectively. The effect of mother's education and whether the father had a white-collar job are explained by respondent's education, household income, and wealth. Higher levels of all of the adult SES measures are associated with fewer functional limitations.

Conversely, whether the father ever temporarily did not have a job before the respondent was age 16 significantly predicts more functional limitations in adulthood for black men, while no early life conditions predict functional limitations for Mexican American men. The effect of paternal temporary unemployment is actually exacerbated when controlling for adult SES

measures, of which only family income is significant. When accounting for the differential amounts of family income among black men, paternal temporary unemployment more strongly predicts functional limitations in adulthood. Lastly, respondent education and household income are associated with fewer functional limitations for Mexican American men.

Again being similar to self-rated health, both the imprinting and accumulation of risk hypotheses are supported for white men due to the sustained impact of early life conditions as well as the influence of later SES on adult health. For black men, there is more support for the imprinting hypothesis given the strong impact of paternal temporary unemployment even after adjusting for adult SES.

Chronic Conditions (Table 3)

Unlike previous health outcomes, only father's education significantly predicts chronic conditions in adulthood among white men. Having a father with more education is associated with fewer chronic conditions in mid- to late-life. The effect of paternal education, however, is explained by family income and wealth.

Among black men, mother's education significantly predicts chronic conditions in adulthood, even when controlling for adult SES. Having a mother with more education is associated with fewer chronic conditions in mid-to late-life. Moreover, no adult SES measures are significantly associated with chronic conditions. It appears as if the only socioeconomic circumstances affecting chronic conditions for black men is mother's education.

For Mexican American men, no childhood conditions are associated with chronic conditions in adulthood, but higher household income in adulthood is associated with fewer chronic conditions.

In contrast to self-rated health and functional limitations, only the accumulation of risk hypothesis is supported for white men while the imprinting hypothesis is supported for black men.

Conclusions

This study extends prior research by combining intersectionality and life course approaches to examining racial and ethnic differences in the relationship between early life conditions and health in mid to late life among men. The results indicate that early life conditions predict health in adulthood primarily among white men. Very few of the childhood experiences measured in this study are associated with health in adulthood for black, and particularly Mexican American, men. Furthermore, support for the imprinting (or latency model) and accumulation of risk (or pathway model) hypotheses varied by race and ethnicity. Both the imprinting and accumulation of risk hypotheses were supported for white men, whereas the imprinting hypothesis was primarily supported for black men. For most outcomes, none of the hypotheses were supported for Mexican American men given the general insignificance of early life conditions on adult health for these men. Overall, these results seem to parallel findings showing that the robust relationship between adult SES and health does not always hold for African Americans (e.g., Colen 2011; Colen et al. 2006; Smith, Kelly, and Nazroo 2009). Thus, similar to theoretical arguments that the universality of the relationship between SES and health should not be assumed (e.g., Pearson 2008), perhaps the relationship between early life conditions and health in adulthood should be reconsidered or more thoroughly examined.

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Table 1. WLS Coefficients of Self-Rated Health Regressed on Early Life Conditions^a

	WM 1	BM1	HM1	WM2	BM2	HM2
	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate
Mother's Education	-.172*** (.04)	-.206 (.12)	-.227 (.16)	-.079* (.04)	-.090 (.12)	-.102 (.15)
Father's Education	-.138*** (.04)	-.159 (.14)	-.325* (.16)	-.075* (.04)	-.119 (.14)	-.183 (.16)
Childhood Poverty	.042 (.04)	.015 (.09)	.033 (.09)	.012 (.03)	-.039 (.09)	-.010 (.09)
Ever Moved	.063 (.04)	.038 (.11)	-.000 (.11)	.041 (.04)	.073 (.11)	-.027 (.11)
Ever Received Financial Help	-.028 (.05)	-.025 (.12)	-.065 (.16)	-.001 (.04)	.025 (.11)	.032 (.15)
Father Did Not Have Job	.014 (.04)	.112 (.11)	.146 (.13)	.006 (.04)	.127 (.11)	.175 (.13)
Never Lived with Father	.120 (.09)	-.205 (.17)	-.064 (.21)	.125 (.09)	-.200 (.16)	-.046 (.20)
Father Had White Collar Job	-.116** (.04)	-.052 (.20)	-.283 (.17)	.030 (.04)	.099 (.20)	-.181 (.17)
Ever Lived with Grandparents	-.068 (.04)	.087 (.09)	.022 (.10)	-.051 (.03)	.081 (.09)	.054 (.10)
Education				-.059*** (.01)	-.035** (.01)	-.045*** (.01)
Household Income				-.138*** (.02)	-.105*** (.03)	-.087*** (.02)
Wealth				-.351*** (.06)	-.852* (.36)	-.055 (.07)
Intercept	2.099*** (.32)	2.299** (.82)	1.569 (.88)	9.576*** (.95)	16.656** (5.24)	4.145** (1.39)
R ²	.11	.08	.13	.16	.12	.18
N	5388	809	642	5388	809	642
F-Statistic	25.09	2.58	3.43	36.51	3.87	4.61

[†]p<.10; *p<.05; **p<.01; ***p<.001

Note: WLS regression coefficients; standard errors are in parentheses

^aAll models control for age, marital status, birth cohort, health in childhood, nativity, and missings on early life condition measures

Table 2. WLS Coefficients of Functional Limitations Regressed on Early Life Conditions^a

	WM 1	BM1	HM1	WM2	BM2	HM2
	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate
Mother's Education	-.241* (.09)	-.594 (.36)	-.485 (.43)	-.030 (.09)	-.376 (.36)	-.246 (.43)
Father's Education	-.374*** (.09)	-.231 (.41)	.144 (.44)	-.227* (.09)	-.158 (.41)	.350 (.45)
Childhood Poverty	-.033 (.09)	.130 (.26)	.275 (.26)	-.088 (.09)	-.065 (.26)	.221 (.26)
Ever Moved	.310** (.10)	.372 (.33)	.111 (.31)	.251* (.10)	.448 (.32)	.075 (.31)
Ever Received Financial Help	-.018 (.11)	-.193 (.34)	.087 (.43)	.057 (.11)	-.026 (.34)	.272 (.43)
Father Did Not Have Job	-.109 (.10)	.710* (.34)	.347 (.35)	-.140 (.09)	.783* (.34)	.370 (.35)
Never Lived with Father	.242 (.23)	-.143 (.50)	-1.003 (.57)	.249 (.22)	-.139 (.49)	-.967 (.57)
Father Had White Collar Job	-.228* (.10)	.728 (.61)	-.404 (.47)	.096 (.10)	1.031 (.61)	-.238 (.47)
Ever Lived with Grandparents	.044 (.09)	.076 (.26)	.141 (.29)	.089 (.08)	.040 (.26)	.175 (.28)
Education				-.127*** (.01)	-.048 (.04)	-.060* (.03)
Household Income				-.332*** (.03)	-.353*** (.08)	-.209*** (.06)
Wealth				-.816*** (.16)	-1.804 (1.06)	-.076 (.20)
Intercept	-.940 (.80)	-2.330 (2.51)	-2.466 (2.50)	16.338*** (2.30)	28.900 (15.54)	2.114 (3.90)
R ²	.11	.08	.13	.16	.12	.16
N	5388	809	642	5388	809	642
F-Statistic	25.78	2.78	3.59	36.03	3.78	3.92

[†]p<.10; *p<.05; **p<.01; ***p<.001

Note: WLS regression coefficients; standard errors are in parentheses

^aAll models control for age, marital status, birth cohort, health in childhood, nativity, and missings on early life condition measures

Table 3. WLS Coefficients of Chronic Conditions Regressed on Early Life Conditions^a

	WM 1	BM1	HM1	WM2	BM2	HM2
	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate
Mother's Education	-.037 (.04)	-.236* (.11)	-.103 (.13)	-.010 (.04)	-.222* (.11)	-.070 (.14)
Father's Education	-.077* (.04)	.106 (.13)	-.083 (.14)	-.058 (.04)	.116 (.13)	-.075 (.14)
Childhood Poverty	.055 (.03)	.039 (.08)	.020 (.08)	.050 (.03)	.042 (.08)	.017 (.08)
Ever Moved	-.031 (.04)	-.044 (.10)	.054 (.10)	-.039 (.04)	-.050 (.10)	.052 (.10)
Ever Received Financial Help	.013 (.04)	.057 (.11)	-.102 (.14)	.019 (.04)	.067 (.11)	-.078 (.14)
Father Did Not Have Job	-.004 (.04)	.110 (.11)	-.170 (.11)	-.008 (.04)	.114 (.11)	-.170 (.11)
Never Lived with Father	.057 (.09)	.194 (.15)	.009 (.18)	.059 (.09)	.193 (.15)	.016 (.18)
Father Had White Collar Job	-.016 (.04)	-.221 (.19)	-.090 (.15)	.023 (.04)	-.215 (.19)	-.080 (.15)
Ever Lived with Grandparents	-.014 (.03)	.013 (.08)	.075 (.09)	-.010 (.03)	.016 (.08)	.072 (.09)
Education				-.007 (.01)	.005 (.01)	-.000 (.01)
Household Income				-.055*** (.01)	.002 (.03)	-.049* (.02)
Wealth				-.257*** (.06)	-.615 (.34)	-.058 (.06)
Intercept	-.180 (.31)	.191 (.77)	.819 (.79)	4.224*** (.92)	9.056 (4.91)	2.164 (1.24)
R ²	.13	.12	.15	.14	.12	.16
N	5388	809	642	5388	809	642
F-Statistic	3.84	3.93	3.95	29.84	3.65	3.81

[†]p<.10; *p<.05; **p<.01; ***p<.001

Note: WLS regression coefficients; standard errors are in parentheses

^aAll models control for age, marital status, birth cohort, health in childhood, nativity, missings on early life condition measures, and whether respondent had private health insurance