

Report of the Second Conference on Aging in the Americas (SCAIA)

Hispanic Health and Aging in a New Century



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Report of the Second Conference on Aging in the Americas (SCAIA)

Key Issues in Hispanic Health and Health Care Policy Research

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Lyndon B. Johnson School of Public Affairs

The University of Texas at Austin



Preface

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The Second Conference on Aging in the Americas (SCAIA) was held September 21-22, 2005, at the Lyndon B. Johnson School of Public Affairs at the University of Texas at Austin. The conference brought together scholars in the fields of Hispanic health, health care policy, and aging research with the goal of sharing and fostering research that improves our national understanding of aging in the Americas and informs the development of science, policy, and aging services.

This volume presents an overview paper on Hispanic and Mexican American health and aging from the SCAIA co-organizers, abstracts of research papers presented at the conference, and abstracts of posters presented by graduate and post-doctoral students participating in SCAIA.

While a wide variety of issues and opinions were covered at SCAIA, three themes stand out: (1) there is a Hispanic aging boom driven in part by the fact that Hispanics live longer than non-Hispanic whites, (2) longer years of life for Hispanics do not translate into healthier years of life, and (3) for many Hispanic populations, particularly those residents of the U.S.—Mexico border, aging must be understood in a bi-national context.

The Hispanic Aging Boom.

The focus of SCAIA on the Hispanic aging experience comes at a time of growing recognition of the influence of Hispanic communities. Of course, this new “discovery” of Hispanics by the media and policymakers comes despite the fact that those of Spanish-

origin were exploring the continental U.S. 125 years before the Pilgrims landed on Plymouth Rock.

Hispanics now represent 46.5 million persons in the U.S., including the Commonwealth of Puerto Rico. Today Hispanics are 15% of the U.S. population and are projected to represent at least 25% of the population in the year 2050. The papers presented at SCAIA demonstrate that population growth is found not only in younger population segments, but that the size of the Hispanic older adult population will triple over the next two decades.

Key to this growth is that the mortality rates for Hispanic populations, are generally lower than those for non-Hispanic whites. Despite having less access to health care, less education, and less income, Hispanics live longer than non-Hispanic whites. Hispanics that fare best tend to be those that are more connected to their culture and community offering important lessons for all on the positive role of connectedness and family, faith, and culture in the Hispanic aging boom. In addition, the conference papers highlighted the importance

of research to understand the role of place, socioeconomic status, and migration and re-migration, legal status, gender, and family roles among other factors to build a more robust understanding of healthy aging in the Americas.

More Years of Life, Not Healthier Years of Life.

The papers presented at SCAIA lay out a foundation for understanding the central paradox of aging in Hispanic communities. While Hispanics live longer lives, they are not healthier lives. Chronic illness and disease defines aging for many Hispanics. Despite living longer Hispanics tend to have higher disability rates, functional impairments, and rates of chronic diseases such as diabetes. At the same time, the lack of access to health insurance and health services means that Hispanics are less able to take advantage of health services to prevent complications and manage and treat chronic illness that is limiting healthy aging for Hispanic communities.

The evidence presented at this conference points to a lack of cultural proficiency in the health system as a key access barrier to services that would help Hispanic communities manage the impact of chronic disease. Evidence was presented that services that paid attention to cultural characteristics were well utilized by the lowest income Hispanic populations and had a measurable positive impact on prevention and management of disease.

Aging in the Americas.

Given its Texas setting, SCAIA addressed the unique relationship of Mexico and the United States with a majority of papers presented focusing on the Mexican American aging experience. The location of this conference highlighted one of the organizing themes for the gathering. To understand aging for Hispanic communities, aging needs to be understood in the context of the Americas.

There was an impressive body of research presented at this conference demonstrating that immigration status, re-migration, and acculturation issues play a significant role in aging and health. There was also evidence of the bicultural and multicultural lives led by Hispanics and how that outlook must be incorporated into aging services in order for them to meet the challenges of the next aging boom.

Just as Hispanics have come to define much of popular youth culture; the longevity of Hispanics means that aging in America will be redefined by Hispanic culture and values.

As that data presented at SCAIA showed, a longer life may very well be found in connectedness to culture, family, faith, and community. They are lessons important to understand not only for aging in Hispanic communities, but for healthier lives for all communities.

Hispanic and Mexican American Health and Aging in a New Century

An Overview

Second Conference on Aging in the Americas
Key Issues in Hispanic Health and Health Care Policy Research

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Introduction

At the beginning of the Twenty-first Century, Hispanics have changed the face of America. By 2001 they had surpassed non-Hispanic blacks as the nation's largest minority group — 37 million versus 36.1 million (U.S. Census Bureau, 2004). Hispanics now make up 15% (46.5 million persons) of the U.S. population, including the commonwealth of Puerto Rico (U.S. Census Bureau, 2006). High fertility and legal and illegal immigration from Mexico and other Latin American countries will assure growth in the future. This report examines key aspects of this growth for elderly Hispanics and for Mexican-origin individuals in particular. These include economic challenges, lack of health insurance and access to medical care, all of which may result in compromised health, and limited options for elder care and their living arrangements. They also have substantial implications for health and social policy.

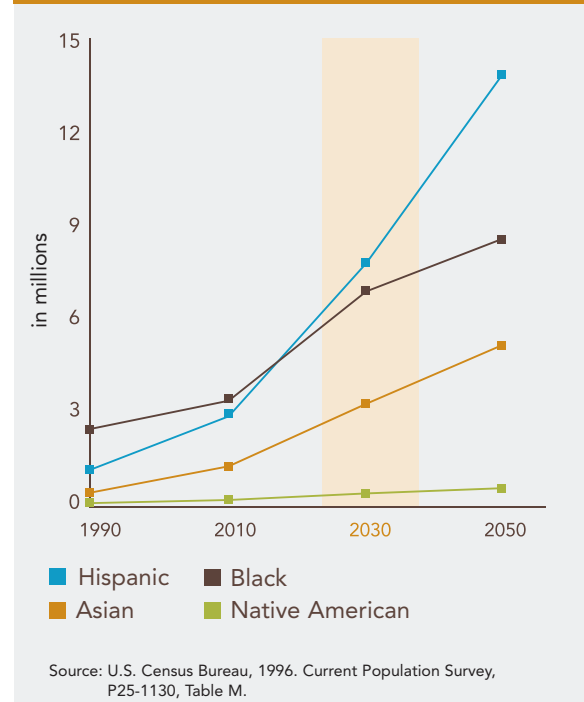
There is a Hispanic aging boom.

Although the Hispanic population is younger than the non-Hispanic population, the population is rapidly aging (Angel & Hogan, 2004). As figure 1 shows Hispanics 65 years and over are projected to outnumber elderly black Americans by one million people in 2030. According to the Census Bureau, the number of elderly Hispanics is expected to climb to 13.8 million by the year 2050.

Mexican Americans are the largest Hispanic group. They represent nearly fifty percent of the total Hispanic population. Mexican Americans

differ from the majority of Americans in terms of numerous factors, most notably educational level, labor force experiences, generational status, area of residence, English language proficiency, and social support. Similar to many of today's Hispanics, a large proportion of the next generation of Mexican Americans will be poorly educated and have limited economic resources (Angel, Angel, Lee, & Markides, 1999). These risk factors accumulate over the life course and undermine health and well being. Mexican Americans are less likely than the Hispanic population at large to have a high school degree

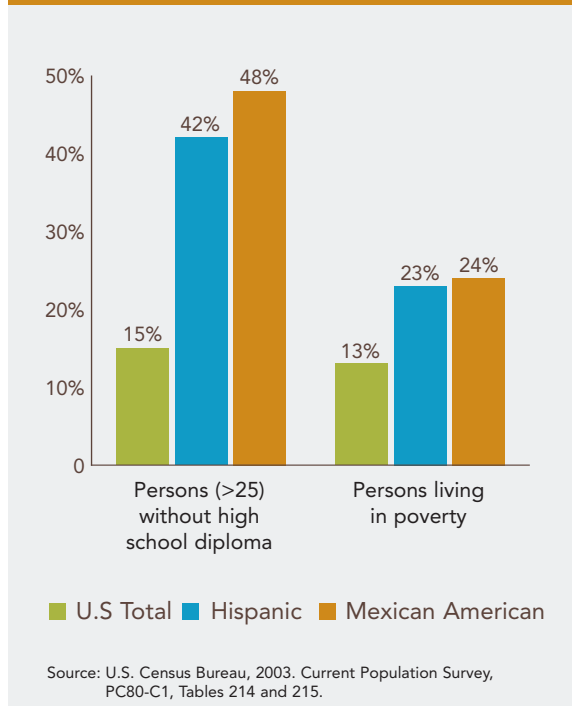
Figure 1. Growth of Minority Elderly (Age 65+) Population (1990–2050)



“Hispanics are the most rapidly growing and dynamic elderly ethnic group in the United States.”

(48% versus 42%, respectively). Twenty-four percent of Mexican Americans live in poverty compared to 23 percent of Hispanics and 13 percent of the total U.S. population (see Figure 2).

Figure 2. Socio-Economic Indicators for Hispanics and Mexican Americans



Hispanics, especially in female-headed Mexican-Americans households, on the cusp of retirement report fewer financial assets than non-Hispanics of the same age group (see Figure 3). These differences no doubt persist into old age.

Elderly Hispanics and especially elderly Mexican Americans face financial risks.

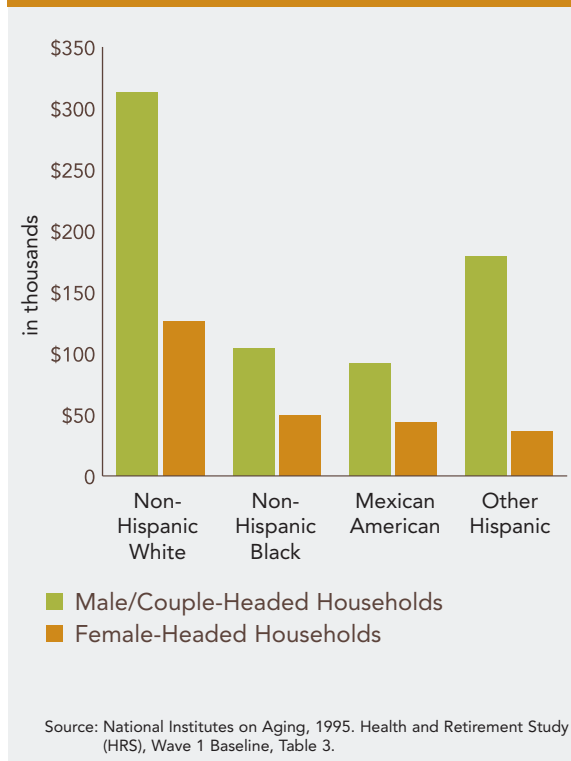
Arguably, a lifetime of low pay fails to build the financial resources necessary to support Hispanics' health-care needs and wellness in later years. Older Mexican immigrants, especially those who immigrated to the United States in the middle or late adulthood, face particular financial problems and may lack the time needed to contribute to the Social Security System, formally called the Old Age, Survivors, and Disability Insurance (Angel, et. al., 1999). Foreign-born Mexican-Americans aged 65 and over, consequently, depend heavily on their family for financial support (Angel and Angel, 1997). Conversely, fewer immigrants report receiving Social Security and private retirement.

Elderly Hispanic legal immigrant residents are much more likely to live in poverty than their citizen counterparts (Angel & Angel, 2006). Elderly Hispanic immigrants typically retire on less than two-thirds of what aged citizens receive (Friedland and Pankaj, 1997). Prior to welfare reform, elderly immigrants reported an annual income of \$5,958 (roughly \$497 per month), almost 95 percent of which was directly from the Supplemental Security Income (SSI), the federal

cash assistance program for the aged, blind, and disabled. While much federal public assistance covered the needs of the elderly population before welfare reform legislation in 1996, which is formally called the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), the U.S. welfare reform created an unmet financial need for the elderly legal immigrant population (Angel, 2003). Before PRWORA legal immigrants were eligible for SSI. With enactment of PRWORA, legal immigrants

became ineligible for SSI if they entered the U.S. after August 22, 1996 until they become U.S. citizens or can be credited with 40 quarters of work. The impact has been that use of SSI by legal immigrants has declined by 32% since before enactment of PRWORA, putting many elderly legal immigrants at financial risk (Immigration Policy Center, 2003).

Figure 3. Racial and Ethnic Group Differences in Wealth among Pre-Retirement Age Individuals: 1992.



Health Vulnerabilities among Older Hispanics and Mexican Americans

Elderly Mexican Americans face significant health risks.

Inequities in health and health care in midlife can widen health disparities between non-Hispanic whites and Hispanics in later life. Older Hispanics have higher disability rates than older non-Hispanic whites (Markides, Eschbach, Ray, and Peek, 2005).

Indeed, chronic illness and disease defines the health experience for many older Hispanic adults. For example, rates of diabetes among Mexican American adults is twice the rate for non-Hispanic whites (Cowie, et. al. 2006). Furthermore, older adult Hispanics with diabetes are more likely than non-Hispanic white diabetics to experience complications such as diabetic-related eye disease (Muñoz, Klein, Rodriguez, Snyder, R., & West, 2005).

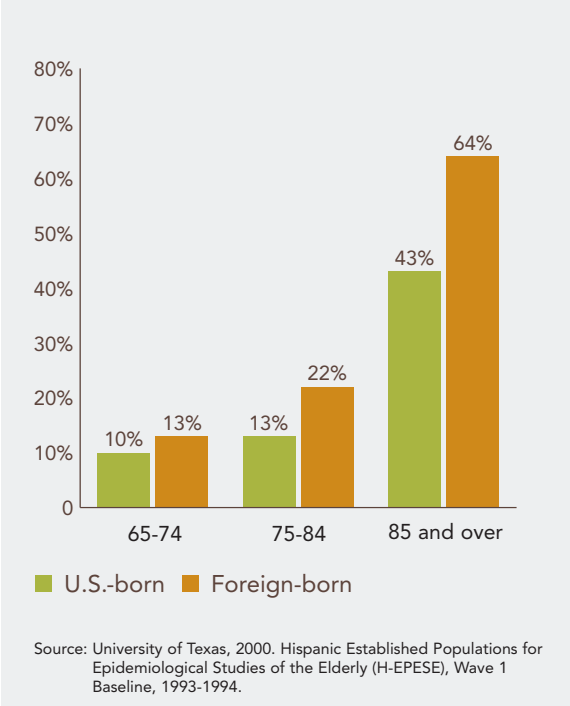
These health disparities associated with Mexican American ethnicity are linked in part to obesity and lifestyle factors such as diet and exercise (Haffner, Hazuda, Mitchell, Paterson & Stern, 1991). Genetic factors may also help explain the high rates of diabetes among Mexican Americans. Adopting westernized lifestyles is often associated with high-fat diets, unwanted daily stressors, and insufficient exercise routines contributing to higher rates of diabetes. Consequently, diabetes and other chronic conditions can lead to deficits in a person’s functional capacity.

Chronic illness and disease, such as diabetes, and its complications limits the quality of longer years of life for many older adult Hispanics. In

fact, over half (56%) of Hispanic older adults report they are living with a chronic condition (Center on an Aging Society, 2003).

The nativity status of Mexican Americans appears to be one factor in old-age disability. Compared with their native born peers, foreign-born Mexican Americans report a higher need for assistance with basic activities of daily life like bathing and toileting. Figure 4 highlights how the aging process itself more than quadruples the risk of functioning deficits among elderly Mexican American immigrants located in Texas.

Figure 4. Elderly Mexican-American Texans with Activities of Daily Living (ADL) Disability by Age and Nativity



“Late-in-life immigrants are the group of elderly least likely to having adequate health insurance coverage.”

As in the population at large, those 85 or older are the fastest growing segment of the elderly Hispanic population and many of these individuals suffer from mental as well as physical problems. Hispanics age 85 and older are projected to comprise 2.6 million of the U.S. population in 2050. Providing cost-effective and appropriate long-term care services to Hispanics above age 85 requires a clear understanding of their unique needs.

Particular health risks are faced by individuals working in industries along the U.S.-Mexico border (Jasso, Rosenzweig, Massey & Smith, 2004). Some of these workers have been exposed to environmental health hazards caused by water and air pollution from manufacturing industries, such as the maquiladoras with foreign ownership in the U.S.-Mexico border (Williams, 1996). Physically demanding work, poor remuneration, and safety hazards in North-Mexican factory plants pose serious health risks, which result in chronic health problems along the U.S.-Mexico border (Becerril, Harlow, Sánchez, Sánchez &, Monroy, 1997; Homedes & Ugalde, 2003). Adverse environmental conditions put workers

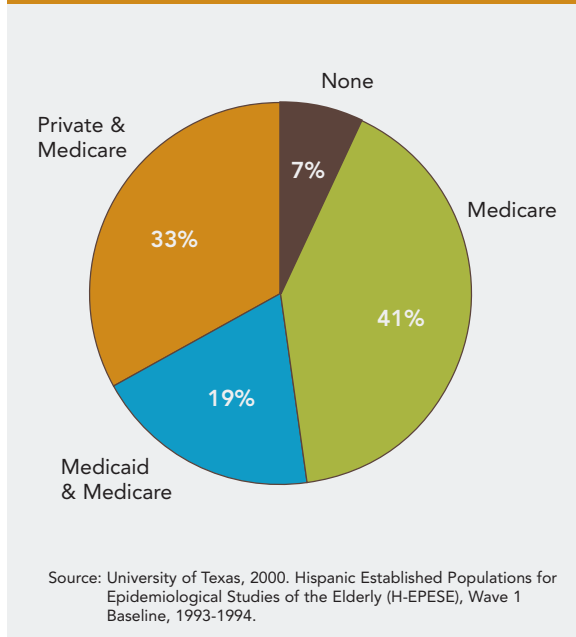
in Mexican communities at risk for serious health problems, including a high incidence of multiple chronic diseases and related disabling chronic conditions requiring long-term care services and supports. Relaxed regulations under U.S. international trade agreements like the North America Free Trade Agreement (NAFTA) and the World Trade Organization's (WTO) General Agreement on Trade and Services (GATS) may have led to or exacerbated these threats to public health and safety.

Individuals of Mexican origin have limited access to health care.

Individuals of Mexican origin are disproportionately represented among those who suffer labor market disadvantages, a fact that has serious negative consequences for their material well-being and health care access throughout their life course. Mexican American children and adults have the lowest rates of health insurance coverage of any group in the nation. Even after the age of sixty-five when they become eligible for Medicare an estimated seven percent of elderly Mexican Americans do not participate in the Medicare program. In addition, those who do are less likely than other groups to own supplemental Medigap plans to cover the costs of what Medicare will not pay (see Figure 5).

Health care coverage appears to be associated with immigrant status among the Mexican-origin elderly. Foreign-born Mexican Americans have lower levels of private employer-sponsored coverage than native born or non-Hispanics.

Figure 5. Health Insurance Coverage for Older Mexican Americans (Age 65+) in the Southwestern U.S.



Those who immigrated in mature adulthood are at particularly elevated risk of having inadequate insurance coverage (Angel & Angel, 2006) as depicted in Table 1.

Mexican American’s limited access to health care has socio-economic reasons.

Reasons for the low rates of health insurance coverage among Mexican Americans are multifold. Regional concentration, labor market differences, income, transportation, immigration status, language access and other social and cultural barriers can increase the risk of inadequate health coverage (Angel & Angel, 1996). For Hispanic working uninsured, income is a key determinant of access to health care along with structural and cultural barriers to seeking medical treatment. Low wage jobs in the retail,

Table 1. Health Insurance Coverage for Older Mexican Americans (Age 65+) by Select Nativity Characteristic

	No Insurance	Medicare only	Medicaid & Medicare	Private ¹ & Medicare
Late-Life Migration	17.9	35.4	41.6	5.1
Middle-Age Migration	4.9	49.5	35.7	9.9
Childhood Migration	4.0	38.3	41.8	15.9
Native Born	1.8	37.6	37.5	23.2
Sample size	125	1,186	1,125	527

¹ Includes military health care, i.e., CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services). CHAMPVA (Civilian Health and Medical Program of the Department of Veteran’s Affairs).

“There is a lack of culturally welcoming nursing homes.”

restaurant, hotel, cleaning, and other service sectors do not offer health insurance, or even if they do, the premiums an employee must pay for family coverage make it an unrealistic family budget item. While Mexican American adults are overrepresented among those who cook our food, clean our offices and homes, and care for our children and gardens, they most likely receive minimum pay and no benefits. Because of life-long labor force disadvantages, retirement-age Mexican Americans have far less wealth than non-Hispanic whites with which to buy health care services or long-term care. The consequences of these life long disadvantages in health care coverage place Mexican Americans at elevated risk of having preventable health problems and a diminished quality of life.

Summarily, Hispanics are at higher health risks in old age. These risks are exacerbated for Mexican Americans, who have severe financial and health needs in old age. What follows next is a discussion of the paradox that Hispanics tend to live longer despite socioeconomic challenges and health risk factors.

Immigration and Hispanic Healthful Aging

Is there a mortality advantage of Mexican-American immigrants?

Even though they have a generally poor socioeconomic profile, Hispanics have lower mortality rates than non-Hispanic whites in almost every age bracket, including those 65 years of age and older (Markides & Eschbach, 2005). Several studies attribute the potential Hispanic mortality advantage to social, cultural, genetic, and health care system factors (Jasso, et al., 2004). Some researchers attribute part of the health profiles of Hispanic immigrants to positive migrant selection (Hummer, Rogers, Nam, & LeClere, 1999; Vega, Kolody, Aguilar-Gaxiola, Alderete, Catalano, & Caraveo-Anduaga, 1998). With regard to specific disease mortality researchers

have found that foreign-born Mexican American elders have a lower risk of death and dementia due to type-2 diabetes than do U.S.-born Mexican American elders (Haan, Mungas, Gonzalez, et al., 2003).

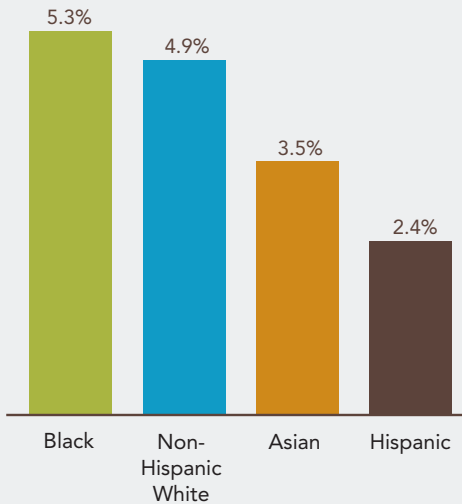
Longer life does not mean healthier years of life.

The mortality advantage in foreign-born Mexican Americans is related to a wide variety of factors, including social and cultural factors such as family connectedness and the positive role of culture in health as well as to genetics and health system factors (Jasso et al. 2004). Understanding the mortality advantage of Hispanic populations, including immigrants, is the subject of a new National Institutes of Health (NIH) sponsored Hispanic Community Health Study representing the largest long-term study of health and disease in Hispanic communities (NIH, 2006).

What we do understand today, particularly for older adult Hispanic populations, is that longer years of life does not mean healthier years. In general, foreign-born elderly appear to fare worse than the native born in several dimensions of health (Angel et al., 2001). For example, research shows that elderly Mexican American immigrant women report more problems with instrumental activities of daily living and a greater need for family assistance than their native-born counterparts (Angel et al., 1996).

For foreign-born older adult Hispanics, the factor of when they arrived in the United States during their life-time also has an impact on health and

Figure 6. Institutionalized Population (Age 65+) by Race/Hispanic Ethnicity: 2000



Source: U.S. Census Bureau, 2000:SF-1, P30 B,C,H,I.

well-being (e.g., Angel, Buckley, & Sakamoto, 2001). Migration, defined in terms of moving from one's culture of origin, in middle and later life, entails significant life events and numerous chronic strains that can undermine an older Mexican immigrant's well-being (Angel and Angel, 1992). For an immigrant that comes to the United States in mid-life, years of residence may not lead to increased integration, but to social and economic disadvantages and their detrimental effects (Wong & Espinoza, 2004). The Health and Retirement Study (HRS) data and other research points to an increased risk for foreign-born older adults with regard to disability (Angel et al., 2001; Hayward & Heron, 2000). It also shows that middle-aged Mexican Americans are more likely to be disabled and for longer time periods compared to their non-Hispanic white peers.

La Familia and Elder Care.

According to the 2000 Census less than three percent of older Hispanics reside in a U.S. nursing home, compared to the U.S. average of approximately five percent (see Figure 6). A host of cultural, demographic, and economic factors explain this pattern in long-term care. For Mexican Americans, nativity status often means a traditional cultural orientation versus a less traditional, more "American" orientation. Cultural groups with higher fertility, such as Mexican Americans, have a greater number of family members available to help care for infirm parents. In addition, adult children may feel obliged to care for their aging parents

because of culturally-based norms associated with Hispanic ethnicity Mexican-American children may keep their elderly parents out of nursing facilities because they do not view nursing homes as a culturally viable alternative. In part, Mexican American elderly are more likely to remain in the community than to enter a nursing home because the family prefers it that way as well as a lack of culturally acceptable facilities (Angel, Angel, McClellan & Markides, 1996).

Elderly Mexican Americans have a stronger desire than their native born peers to live within an extended family household in the event of diminished capacity (Angel et al., 1996). Foreign-born Mexican-origin elderly tend to have poor health when they arrive in the United States and thus coreside with adult children (Angel & Angel, 1997).

Besides the role that culture plays in accounting for the lower rates of nursing home use, there are other reasons for the higher rates of family caregiving among Mexican Americans. Elderly Hispanics are also more likely to be poor, and consequently, unable to pay for options such as assisted living. Also, there is a lack of culturally welcoming nursing homes geographically built within Mexican-American communities.

Implications for Aging in the Americas

Not so long ago, the biggest health problems for developing countries like Mexico were associated with the exponential growth of young populations while wealthy countries like the United States faced falling birth rates and the decline in the working-age population (Ham & Claude, 1990). Currently, however, an exponential growth in the elder population is taking place in both developed and developing countries of the Americas (Frank, 2004).

Because the aging of the population is poised to explode in coming years, policy makers in the Americas are increasingly becoming aware of the burgeoning health care needs, especially of aging Hispanic populations. Both the United States and Mexico must address the health and social support needs of older adults as well as recognize the extraordinary talent and resource they represent.

Young Hispanic adults face increased care giving needs by their elderly parents.

With regard to North America, numerous factors will affect the health security of Mexican American families and individuals as they face the burdens of decline in health status and caring for children and the elderly simultaneously.

The rapid growth of the older Mexican American population has serious implications for younger generations who are facing the burden of caring for older generations (Roberts & Latapi, 1997). These include financial responsibilities for the young Hispanics because in both Mexico and the

United States most elderly Hispanics live outside institutions designed specifically for their care (Palloni, Soldo, & Wong, 2002). For emotional as well as for material support, informal sources that include relatives, friends, and neighbors are vital supplements to the available formal support systems, especially in situations in which the formal support system is underdeveloped.

Flows of remittances to Mexico are non-persistent.

Population aging affects Hispanic intergenerational relationships and financial well being (Wong & Espinoza, 2005). Flows of assistance seem non-responsive to particular older Mexican health care needs, but are also driven by cultural norms. Adult Mexican children whose parents invest more in education, health, and other social capital in their upbringing tend to be more likely to make financial transfers to their parents. On the other hand, children who receive fewer opportunities are more likely to make time and other in-kind transfers to their parents.

To some extent, established networks on both sides of the U.S.-Mexico border have made the migration process easier, and therefore aging Mexican families are less selective in choosing which family members should migrate. Because of this lack of selectivity, current levels of health and education of Mexican-born immigrants in the United States may decrease compared to earlier migrants.

A Health Policy Research Agenda for Older Hispanics.

As of yet little knowledge exists about the notable strengths, characteristics, and experiences of Hispanic groups as they age. Knowledge in the following six areas could contribute to the development of innovative policies on Hispanic elder care in the Americas.

1. Compare Differences In Elder Care In the U.S. and Mexico.

How do institutional and social factors influence the situation of elderly Mexican Americans in the United States as opposed to elderly Mexican nationals in Mexico? This knowledge would provide new insights in areas where much coordination of health and social services is needed for Hispanic families. Caring for elderly parents will require developing innovative methods for overcoming private and institutional obstacles.

2. Identify Elder Health Indicators in the U.S.-Mexico Border Region.

Demographic studies of the U.S.-Mexico border would help identify health and illness behavior. Research along these lines, could inform specific policy interventions with regard to the prevention of diseases and how to improve and protect Hispanic health. Promising research would help to understand the pattern of expanded chronic diseases as residents along the U.S.-Mexico border advance in age.

3. Identify Health Characteristics of Recent Mexican Immigrants.

Many Mexican workers migrate permanently to the United States for work, offsetting the negative effects of aging in the U.S. Approximately 400,000 Mexicans have been crossing the U.S.-Mexico border annually since the late 1990s (U.S.-Mexico Bi-national Council, 2004). Knowledge on the variability in long-term mental and physical health consequences of Mexican labor migration to the United States is paramount. Future research, for example, could examine the effects of this out migration on health care for older Mexicans. What is the health and socioeconomic impact of selective migration on foreign-born Mexican Americans as they age in the United States? For instance, National Health Interview Survey (NHIS) data could be linked with the National Death Index (NDI) to document health and longevity in the Mexican American population (Markides & Eschbach, 2005).

4. Identify the Effects of Migration on Mexican Social Security.

Issues related to the dynamic transfers of resources from the United States to Mexican households aimed at health care from kinship on both sides of the border deserve attention. Knowledge in the following areas could address health policy needs in the Americas: Do the remittances received from young migrant workers reduce the contributions to the Mexican old-age welfare state? How will the migration of adult children from Mexico to

the United States help or hurt local Mexican savings and investment to support a Mexican aging society? And vice versa, how will this migration affect the health care situation of Mexican Americans in the United States? How do financial contributions to Mexican parents affect the health status and medical care use of both Mexican-origin individuals and their adult children as they age?

5. Identify the Effect of Health-Related Crossings From The U.S. to Mexico.

Five percent of the roughly 350 million annual crossings at the U.S.-Mexico border may be health related (Sekri, Gómez-Dantés, & Macdonald, 1999). Seventy-five percent of these health-related crossings are from the U.S. into Mexico, most often to purchase pharmaceuticals without a prescription, including antibiotics. As of yet, however, little is known about the demographic characteristics of the users of health care.

Viable policy alternatives need to be developed to eliminate health and health care inequalities in the aging Mexican American population. Cross border health insurance, for example, is just one of many alternatives that state governments could develop to care for retirees in Mexico. Other possibilities of health care reform can be learned from concrete examples found in the Mexican experience within the context of the epidemiologic transition.

6. Identify Options Of Family Elder Care In The U.S.-Mexico Borderland.

How will low-income Mexican families now living in the United States care for their aged parents in the context of dramatic demographic change? Although remittances to siblings still living in Mexico already exist, the dynamics of transnational families appears to be changing due to the following:

- a. a greater proportion of permanency in the United States;
- b. dual nationality of native-born Mexican origin citizens;
- c. declining remittances as Mexicans focus on their U.S. family commitments;
- d. growing pressures for family reunification, namely, elderly Mexicans coming to live with their U.S. resident children and grandchildren.

These trends call for housing studies, including the role of colonias and other informal homestead subdivisions. Particularly critical is developing an understanding of the availability of Hispanic community-based elder care services, including culturally welcoming adult day care, assisted living, and nursing homes.

In summary, after years of research, investigators have extended their grasp of complex social and behavioral factors associated with the health of aging Hispanics. That knowledge and experience can inform the development of new institutional arrangements to address Hispanic elder needs. This includes the development of community-based aging services, including assisted living and skilled nursing facilities, that meet the unique needs of Hispanic elders and are culturally welcoming. Supporting improved research and translating knowledge on Hispanic health and aging can also aid in implementing innovative strategies to protect and improve the health and social welfare of the older Hispanic population. Among the most promising area is understanding the positive role that family, faith, community, and culture plays for Hispanic elders. Greater understanding of the Hispanic aging experience and application of that knowledge will improve health and well-being not only in the United States but throughout the Americas.

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Jacqueline L. Angel, Ph.D., who has a Ph.D. from Rutgers University, is a Professor of Public Affairs and Sociology at The University of Texas at Austin. In 1990-92, she was an NIA Postdoctoral Fellow in the Demography of Aging Training Program at The Pennsylvania State University. Her research addresses the relationships linking family structures, inequality, and health across the life course with a special emphasis on populations of Hispanic origin. Currently, she is collaborating with investigators from the UT medical schools in Galveston and San Antonio on a benchmark study of elderly Mexican Americans' health in the Southwestern United States. Her work on this project involves examining the interplay among immigration, health, and aging. She has published numerous articles and chapters related to Hispanic health and social welfare policy as well as three books, *Health and Living Arrangements of the Elderly* (Garland Publishing, 1991), and jointly with Ronald J. Angel, *Painful Inheritance: Health and the New Generation of Fatherless Families* (University of Wisconsin Press, 1993), and *Who Will Care for Us? Aging and Long-Term Care in Multicultural America* (New York University Press, 1997). In 2000, she was elected a Fellow of The Gerontological Society of America.

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He is the member of several professional associations including the Gerontological Society of America, the Society for Behavioral Medicine, and the Society for Multivariate Experimental Psychology. He serves as a chair for the Gerontological Society of America's Task Force on Minority Issues which recently published *Closing the Gap: Improving the health of Minority Elders in the New Millennium*. He was a member of the National Research Council/National Academy of Sciences "Aging Mind" committee and currently serves on the "Research Agenda for the Social Psychology of Aging" committee and the Institute of Medicine committee on "Assessing Interactions Among Social, Behavioral, and Genetic Factors on Health." He is a member of the National Advisory Board for the Center for Urban African

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Abstracts

Second Conference on Aging in the Americas
Key Issues in Hispanic Health and Health Care Policy Research

Prepared by Conference Co-Organizers
Jacqueline Angel
Keith Whitfield



Session 1. Exploring the Health Consequences of Hispanic Mortality

Active Life Expectancy of Older U.S. and Foreign-born Mexican Americans

Karl Eschbach, Soham Al-Snih, Kyriakos S. Markides, James S. Goodwin

Mortality rates for Hispanic populations, especially foreign-born Mexican Americans, are generally reported to be lower than those for non-Hispanic Whites. This is the well-known Hispanic epidemiological paradox. What is less well-known, and may be more paradoxical, is that this mortality advantage occurs despite higher prevalence of morbidity from several chronic conditions and disablement among older Mexican Americans. This research investigates differences in active life expectancy for older Mexican Americans, using data from the H-EPESE cohort of 3,050 Mexican Americans who were age 65 or older at base line in 1993/4. In this study, we report active life expectancy and disabled life expectancy at ages 65 and older for immigrant and native Mexican Americans from the H-EPESE cohort, and compare to data for Whites and Blacks from a pooled data set from other EPESE cohorts (Duke, Iowa, New Haven, East Boston). We then identify causes associated with variation in active life expectancy for older Mexican American immigrants and natives, including both baseline health conditions and social risks, including education, acculturation, and neighborhood characteristics.

Session 1. Exploring the Health Consequences of Hispanic Mortality

Old age Disability Rates by Race/Ethnicity Using the 2000 United States Census

Kyriakos S. Markides, Karl Eschbach, Laura Ray, Kristen Peek

The literature has repeatedly shown that older African Americans are more physically disabled than older Non-Hispanic Whites. As a group older Hispanics are also more disabled than older Non-Hispanic Whites but somewhat less so than African Americans. Limited literature suggests that older Asian Americans are less disabled than older Non-Hispanic Whites while older Native Americans are more disabled. The above generalizations are typically based on limited samples, mostly regional ones, and samples that are not large enough to provide stable disability estimates for smaller ethnic/minority populations. The 2000 United States Census has obtained disability data on five disability items that are similar to the typical Activities of Daily Living (ADL) items commonly used in the literature. Despite some limitations in these data, the large sample size of the five percent sample allows stable estimates of disability rates for relatively small ethnic minority populations as well as type of Hispanic origin. We computed age-adjusted disability rates (overall and item-specific) by race/ethnicity for persons aged 65 and over. As expected results show that older African Americans and older Native Americans appear to be considerably more disabled than older Non-Hispanic Whites. Overall older Hispanics were more disabled than older Non-Hispanic Whites. Among Hispanics, older Puerto Ricans and older Mexican Americans were the most disabled with older Cubans and Central and South Americans being less disabled. Among Mexican Americans no pattern of differences by nativity were observed. Older Asian Americans were somewhat more disabled than older Non-Hispanic Whites despite having a higher life expectancy. On the other hand, older Pacific Islanders had disability rates that are similar to those of Native Americans. These results are discussed in terms of existing literature, immigrant status, disease patterns, socioeconomic conditions and potential cultural factors that might influence reporting of disability.

Session 1. Exploring the Health Consequences of Hispanic Mortality

Life Course, Aging and the Latino Epidemiologic Paradox

Results from the Sacramento Area Latino Study on Aging

Mary N. Haan, Vivian Colón López, Hector M. Gonzalez

A number of studies have reported a mortality advantage accruing to residents of the United States of Mexican origin. The reasons proposed for this have included selective effects of migration on health status, return-migration bias, data artifacts, and socio-behavioral health advantages offered by Mexican culture. People of Mexican origin born in the US have similar or higher mortality than native born non-Hispanic whites and both groups have higher mortality than those migrating from Mexico. Not all evidence supports the existence of this advantage, but most have not evaluated the effects of nativity on disease risk or have grouped together 'Hispanic' groups. This advantage is viewed as a paradox because, compared to non-Hispanic whites, middle-aged and older people of Mexican origin living in the United States generally suffer higher rates of vascular and metabolic risk factors. Cultural change and socioeconomic status (SES) influence behaviors and disease within all race and ethnic groups in the US. This paper evaluates the associations of nativity, immigration, cultural change and SES with death, diabetes and dementia. The Sacramento Area Latino Study on Aging (SALSA) includes 1,800 older (60-100) primarily Mexican Americans. One half of participants were born in the US. Median education was 3 years in Mexican born and 10 years in US born. Nativity affected the risk of prevalent (US oriented vs. Mexican OR= 0.36, 0.21-0.61) and incident dementia (RH=0.50, 0.34-0.95). Among those with less education, mortality in US born was higher than Mexican born (RR=1.44). This was reversed among those with more education (RR=0.74, p=0.01). Type 2 diabetes incidence was higher in US born compared to Mexican born (RH=1.45, p<.0001). At least 50% of dementia and other functional impairments in this study are attributable to type 2 diabetes. Risk of death and dementia are higher among those with type 2 diabetes but are modified by SES and cultural change. Understanding the current health status of older Mexican-origin US elderly requires assessment of life course exposures, immigration/re-migration history, SES, and cultural change.

Session 1. Exploring the Health Consequences of Hispanic Mortality

The Case For The Epidemiological Paradox

Alberto Palloni

I start by summarizing what we know about the Hispanic paradox and establish conditions of possibility for its occurrence. This is done by examining (a) what the empirical facts are and (b) what the alternative explanations may be. I examine the heterogeneity within the Hispanic adult population and classify groups according to their relative health status standings. To the extent one finds that Hispanics (of various subgroups) experience more favorable health status and mortality conditions than some reference groups, one can invoke three alternative explanations. The first attributes the empirical regularities to behavioral profiles and social conditions that are conducive to better health. I examine what these behavioral factors and social conditions are and summarize the extent to which we found them linked to leading causes of morbidity and chronic illnesses. The second explanation has to do with migration selection and the observable patterns one would expect if selection were indeed operating. Countering the effects of selection are the negative effects associated with migration per se (stress, lack of information and access, unfavorable economic conditions) and its aftermath (acquisition of unfavorable behavioral patterns, negative consequences of assimilation). These effects may dominate over selection effects among some Hispanic groups. I examine the conditions that may lead to one or the other result. Finally, I examine the role of return migration and the ways in which it can impact on the health status and mortality of both the Hispanic US resident population and the population in the places of origin (Mexico and other sending countries).

Session 1. Exploring the Health Consequences of Hispanic Mortality

Does Longer Life Mean Better Health?

Not for Older Mexican Americans in the Health and Retirement Survey

Mark D. Hayward, David F. Warner, Mira M. Hidajat, Eileen M. Crimmins

Demographic studies of population health point to the chasm separating both the expected length of life and the length of active life (ALE) for black and white Americans. Less is known about how Hispanics fare relative to blacks and whites, and very few studies have examined how these groups differ in the mortality and disability processes that give rise to disparities in ALE. At the same time, ambiguity surrounds the role of education (and socioeconomic status more generally) in contributing to race/ethnic disparities in ALE. Many scholars argue that SES is the underlying cause of race differences in ALE, but how SES influences Hispanic health is less clear. Drawing on longitudinal data from the Health and Retirement Survey (1992-2002), we report the gaps in ALE separating whites, blacks, and Hispanics, and show the educational gradient in ALE for each of the major race/ethnic groups. In this fashion, we assess the degree to which education helps overcome the disadvantages of minority status. The educational gradient in life expectancy is evident, although race (black/white) differences in life expectancy within educational levels are not large. Education rather than race appears to govern inequality in mortality. This is not the case with regard to the years of expected active and inactive life. Although the race groups are similar in life expectancy for a given educational level, we observe substantial race differences in active and inactive life, with blacks spending more years inactive than whites. The educational gradient in active life is also evident for both race groups. As education increases, blacks and whites spend an increasing portion of the lives without functioning problems. Educational attainment is severely truncated for the older Mexican American sub-sample in the HRS compared to the other groups, constraining our ability to determine whether Mexican American ALE follows a similar pattern to that for blacks and whites. ALE was calculated for native-born Mexican Americans with 8 years of education – a prevalent group for whom the data are of high quality. The results reinforce the idea of the Hispanic paradox with respect to mortality. Mortality among Mexican Americans with 8 years of education is lower than mortality among whites with 12 years of education. Despite low mortality, however, Mexican Americans experience a substantially greater number of years with functional problems than blacks or whites regardless of education. For older native born Mexican Americans, longer life does not mean better health. Longer life is associated with a greater burden of disease – a different twist on the idea of the Hispanic epidemiological paradox.

Session 1. Exploring the Health Consequences of Hispanic Mortality

The Association between Socioeconomic Status and Mortality Risk among Hispanics in the United States

Sarah A. McKinnon, Robert A. Hummer

Since the concept of the epidemiologic paradox was first introduced by Markides and Coreil (1986), the health and mortality patterns of Hispanics living in the United States have received a considerable amount of attention in demography and epidemiology. The majority of this research has supported the original conceptualization of the paradox that, in spite of their disadvantaged socioeconomic characteristics, Hispanic populations in the U.S. tend to demonstrate health and mortality rates that are more similar to those of non-Hispanic whites than non-Hispanic blacks. However, in recent years the idea of the epidemiologic paradox has been called into question along a number of dimensions (Palloni and Morenoff 2001; Palloni and Arias 2004). Thus, current research in this area is focused largely on debates involving the impact of such factors as immigrant selectivity, outmigration, and ethnic misclassification as they related to estimated health and mortality outcomes among Hispanic populations (see, e.g., Elo et al. 2004; Hummer et al. 2004). Yet another important point of contention in the epidemiologic paradox literature, and also an understudied issue, involves the association between socioeconomic status and health outcomes among Hispanic populations. That is, if Hispanic populations tend to fare better than their overall socioeconomic status predicts, does the association between socioeconomic status and health work differently for Hispanics than it does for other populations in the United States? The purpose of our discussion paper is to utilize data from the National Health Interview Survey (NHIS) linked with the National Death Index (NDI) to conduct an empirical examination of the association between socioeconomic status and mortality risk among Hispanics in the United States. Specifically, we will estimate and compare educational and income differences in mortality risk across different Hispanic groups and make comparisons to mortality patterns among non-Hispanic blacks and whites. Specific age subpopulations (e.g., 25-44; 45-64; and 65+) will be examined separately to most appropriately compare socioeconomic mortality differentials. As part of this work, we will also differentiate between native- and foreign-born Hispanics and Hispanics by specific ethnic group, because of the heterogeneity that exists within the U.S. Hispanic population. Our research in progress should provide basic, albeit valuable, information regarding the association between socioeconomic status and Hispanic mortality in the United States and add to the growing and controversial literature on the epidemiologic paradox.

Session 2. The Economics of Hispanic Aging
New Findings from Mexican Health and Aging Studies

Dynamics of Intergenerational Assistance in Middle- and Old-Age in Mexico

Rebeca Wong, Monica Espinoza

The paper uses data from the new Mexican Health and Aging Study (MHAS/ENASEM) 2001 and 2003, to describe the dynamics of private inter-vivos transfers for the population aged 50 or older in Mexico. This analysis is particularly relevant in the context of developing countries characterized by scarce or inactive financial markets and limited institutional support for old age. The paper examines the 2-year changes in transfers exchanged between older adults and their children, using descriptive as well as multivariate techniques. The focus is on the determinants of becoming active as well as those of turning inactive in the two directions of the flow of transfers: giving to and receiving from children using two types of inter-vivos informal transfers: monetary and in-time. Findings suggest that family transfers are quite dynamic in Mexico, and respond differently to health shocks or economic conditions depending on the type of transfer. This confirms the importance of informal transfers for the well being of older adults in Mexico. We draw conclusions and make suggestions for future work on the dynamics of intergenerational transfers.

Session 2. The Economics of Hispanic Aging
New Findings from Mexican Health and Aging Studies

Impoverishment and Catastrophic Health Spending In Mexico
Differences Between Households With And Without Older Adults

Felicia Marie Knaul, Héctor Arreola-Ornelas, Oscar Méndez-Carniado

This paper analyzes household health expenditures in Mexico from 1992 to 2004 in terms of catastrophic and impoverishing payments for health care and fairness of finance. The research contributes to the literature by collecting evidence on health financial risk protection over time and analyzing the impact, both present and future, of population aging. The time period of the study the 1994-5 economic crisis and the health reform of 2003 through which a scheme for achieving universal health insurance coverage is being implemented.

The data are from the biannual time series of the National Household Income and Expenditure Survey (ENIGH). Descriptive and econometric analysis is carried out, including a series of studies of the changes in catastrophic and impoverishing payments between 1992 and 2004. Simulation analysis is used to analyze the potential impact of extending financial protection for households as part of the national health system policy towards universal insurance coverage that is encompassed in the health reform of 2003.

The paper begins to identify the potential and observed impact of changes in catastrophic and impoverishing expenditures that can be attributed to the health care reform. The work also analyzes household composition as a determinant of catastrophic and impoverishing health expenditure.

The results on family composition, and specifically aging, show that before 1998, catastrophic and impoverishing expenditures were more common among families with young children and since 2000 they have become more common among families with elderly members. Further, the regression analysis suggests that the presence of a person over aged 65 is a significant determinant of the probability that a family suffers an impoverishing or catastrophic health expenditure. In relation to the future extension of the Mexican health insurance scheme put forward in the reform, the simulation results show that despite the fact that families that include persons over age 65 are not a very large group, covering them will have a large impact in reducing impoverishing and catastrophic health expenditure. This also suggests the importance of expanding the package of insured services to cover chronic and degenerative diseases in subsequent phases of the reform. These tend to include the more expensive health problems in terms of the interventions required and are becoming increasingly important in the burden of disease in Mexico as epidemiologic transition expands.

Session 2. The Economics of Hispanic Aging
New Findings from Mexican Health and Aging Studies

Health, Quality of Life and Aging in the Context of Migration

V. Nellie Salgado

The objective of this presentation is to describe the health status, physical limitations associated with health problems, use of health services and overall quality of life (satisfaction, perceived social support, characteristics of their social, financial, institutional and personal resources) of elderly people that live in contexts of rural and urban poverty, and to explore differences between them from a gender perspective.

This was a descriptive, cross-sectional study that used quantitative and qualitative approaches for data collection. Participants were a purposive sample of 804 males and females 60 and older residing in rural areas (n=404) with less than 5000 inhabitants of the Mexican states of Morelos and Guerrero; and residing in urban ghettos (n=400) of the city capitals of the same two states (Cuernavaca and Chilpancingo, respectively). Poverty forces elderly people to continue working to survive and was perceived as a very limiting factor for attaining “good life”. Their limited income is the only resource they had, since the majority did not have a retirement or pension plan and did not have access to social health care programs. Rural women had the highest prevalence of all types of illnesses and ethnocultural conditions such as nervios, susto and empacho. They also reported suffering more pain, more physical limitations associated with health problems and more use of both, home remedies (a greater variety of them) and medication than their male counterparts. Satisfaction with life was intimately associated with self-perceived health status among all respondents. They made limited use of the health services available in their communities, mostly because they did not have sufficient money to pay for medication and treatment. Perceived family care and support was identified as the single most important factor associated to the construct “quality of life”. Finally women, more than men, had social networks that were characterized by their density, durability, multi-functionality, and effectiveness. Gender roles are a very important factor in determining the way in which elderly people live their last years, this is why programs geared to support the needs of this vulnerable group need to have a gender orientation. Additionally, elderly people that live in poverty need to have adequate social protection and a minimum income to respond to their basic needs. Access to health services for this vulnerable group must be a priority for the national health systems of Mexico.

Session 2. The Economics of Hispanic Aging
New Findings from Mexican Health and Aging Studies

Aging and health interrelations at the USA-MEX border

Roberto Ham-Chande

This paper addresses the interrelations that are taking place between Mexico and United States in the field of family population aging in their border region. The key elements are specific risk factors, economic differentials, care providers and transfers of resources. Research questions are: What are the health, socioeconomic and family characteristics of the elderly at the USA-MEX border region? How does border socioeconomic and demographic interrelatedness impact on health and well-being of the elderly and their family environment? The demography of the Mexican border distinguishes itself by anticipating the fastest decrease in mortality rate and increase in aging in a more intense form than that of the rest of the country. This tendency is similar to the urban zones, but more advanced in the process of the demographic transition. In addition, internal and international migration has been the fundamental components for the accelerated increase of the border population during the 20th century. These dynamics have contributed to particularities in the age structure, mainly on population in working ages.

The Mexican-origin population in the US is aging at a faster pace. Prevention, health care and family ties have substantial socioeconomic and cultural backgrounds. Mexicans are impacting health practices in the US and acquiring new perspectives. A particular situation in the health conditions of elderly in the border, due as much to the adjacency of two societies with great social and economic differences as well as to the importance and frequency of economic, social, and cultural relations of the population that cross through it, is precisely the influence of interrelations. These linkages favor the incidence of certain illnesses in older adults as well as the way they take care of their health. Trans-border issues on elderly health come out in a variety of areas including: bi-national actions for the study and prevention of diseases, bi-national exchange of medicines and health services, and transfers of resources from the United States to Mexican households aimed at health care from kinship on both sides of the border.

Session 3. Health Insurance and Access to Acute and Long-term Care Services among Hispanics

Health Care Disparities and Barriers to Access to Acute and Long Term Health Care of Mexican American Elders

Fernando Treviño, Alberto Coustasse

Much research has been conducted in social gerontology in Mexican Americans over the past two decades. Yet, systematic knowledge and consensus about health care disparities in access and barriers to acute and long-term services is lacking. On the one hand, it is not known to what extent these factors and barriers are affecting Mexican American elders, nor it is known what effects chronic poverty has on aging in this population. The research revealing an underutilization of services by Mexican American elderly holds that this is due in part to lack of knowledge, lack of health insurance, use of informal networks, socio- institutional and socio cultural barriers.

The purpose of the paper is to identify, measure and analyze the barriers Latino elderly face in accessing acute and long-term health care. In addition, the following research question will be addressed: Does chronic poverty in and of itself explain the differential access to and quality of acute and chronic care? The study will employ secondary data, combining quantitative and qualitative methods. The Hispanic Established Population for Epidemiologic Studies of the Elderly (HEPESE) and HHANES instruments will be used, as well as (health care) utilization and discharge data. In addition, on-line database and literature searches will be conducted to identify existing private, public, academic, and philanthropic endeavors to address access of Mexican American elderly to acute and long term services. Interviews of key informants will be performed using a semi-structured open-ended questionnaire. Analysis will be performed using triangulation of above data. Results are anticipated to include primary or financial barriers, secondary or structural barriers, and tertiary or socio-cultural barriers. Furthermore, needs, gaps and duplication of interventions will be identified in the Mexican American elderly community. Based on the above results, the researchers will propose feasible coordinated actions for policy modifications, consumer education, Latino health leadership development, and empowerment and advocacy, to develop a coherent course of action to reduce or eliminate access barriers for the aged Mexican American population to acute and long- term health care services.

Session 3. Health Insurance and Access to Acute and Long-term Care Services among Hispanics

Cross Border Health Insurance Coverage for Elderly Latinos

David C. Warner

This paper will discuss the development of Cross Border Health Insurance in California, Some constraints that currently exist in Texas and the possibility of the development of Medicare coverage in Mexico for retirees there. This will be looked at in particular in terms of elderly Mexican Americans use of cross border resources currently and their likelihood of using them in the future as well as their possibly choosing to retire to Mexico in the future. This paper will build on earlier research on Cross Border Health Insurance and on the issues involved in developing a research and demonstration waiver to care for retirees in Mexico.

Session 3. Health Insurance and Access to Acute and Long-term Care Services among Hispanics

Cultural Myths and Other Fables about Promoting Health in Mexican Americans

Lessons Learned from Starr County Border Health Intervention Research

Sharon A. Brown

Mexican Americans are at risk for developing “New World syndrome,” health problems, including type 2 diabetes, that result from Amerindian genetic admixture and adoption of Westernized lifestyles. In some Mexican American communities, diabetes affects 50% of the adults. Since 1988 we have conducted diabetes intervention research in Starr County, the most impoverished county in Texas and one of the poorest in the U.S.; 98% of the residents are Mexican American. The research involved randomized clinical trials of culturally competent, community-based diabetes self-management interventions and involved: (1) instruction on nutrition, self-monitoring of blood glucose, exercise, and other self-management topics; and (2) group support to promote behavioral changes. The intervention was culturally competent for language, diet, social emphasis, family participation, and health beliefs. A number of myths regarding the culture were identified that posed barriers to improving health: 1) Mexican Americans will not participate in research and are difficult to recruit and retain in studies, 2) Mexican Americans have a genetic predisposition for diabetes that cannot be overcome, 3) “Fatalism,” a belief that diabetes is a punishment, prevents individuals from assuming responsibility for their health, 4) Lifestyle programs are useless since Mexican Americans will not change their lifestyles, 5) Due to traditional gender roles, husbands will not be supportive of their wives with diabetes, 6) Individuals need to adopt more healthy Westernized food habits, 7) Individuals must achieve ideal body weight to improve glycemic control, and 8) Community health workers can fill the health care gap in medically underserved Mexican American communities. The majority of subjects were female and many spouses served as support persons, attending intervention sessions. Attendance at data collection ranged from 81% to 90%. Despite minimal weight loss, glycemic control improved significantly. In a recent study, the top 10% achievers (n=20) reduced HbA1c levels by 6% percentage points. Attention to the cultural characteristics of the population demonstrated the falsity of common preconceived notions held by health care providers and persons with diabetes regarding promoting health in Mexican Americans.

Session 3. Health Insurance and Access to Acute and Long-term Care Services among Hispanics

Health and Socio Economic Disparities among Lower Rio Grande Valley Mexican American Middle Age and Older Adults

Evidence from the Border Epidemiologic Study of Aging

Elena Bastida, Shelton Brown

Three waves of the Border Epidemiologic Study of Aging (BESA) findings will be presented and discussed, specifically addressing five health policy concerns: (1) the impact of socio-economic disparities and increasing age on the prevalence and incidence of chronic disease; (2) percentage reporting health insurance by socio-economic status (SES) and birthplace (Mexico or the US); (3) percent reporting unpaid medical bills; 4) Socio economic status and age of those who regularly utilize Mexican health care, and (5) socio-economic and age differences in US physician and hospital utilization. Data for the BESA were drawn from a larger stratified random sample of 1285 households in Hidalgo and Starr Counties in the Lower Rio Grande Valley of Texas. Selection criteria for household inclusion were determined by age (37 years of age and older) and ethnic origin (Mexican American) of at least one household resident. One resident was interviewed per household. When more than one household resident met the sampling criteria, residents were allowed to volunteer their participation. Spousal data were obtained for married participants. The final sample included 460 participants 65 years of age and older. However, findings reported here are not limited to the 65+ cohort, but are compared and contrasted with three other age cohorts (under 45, 45-54, and 55-64). Cross cohort data analyses are of critical importance in examining current and future public policy directions addressing the Hispanic population. Results from BESA cross cohort data analyses point to a pattern of increased and expanded chronic diseases and socio economic problems as these cohorts advance in age.

Session 3. Health Insurance and Access to Acute and Long-term Care Services among Hispanics

Access Issues in the Care of Mexican Origin Elders

David V. Espino

The Mexican origin elder population is growing rapidly. As opposed to their younger counterparts, elders in general consume a greater proportion of the health care dollars and are more likely to seek health care services. There are a variety of challenges that confront this unique group of elders when seeking both acute and long term health care. These challenges include (1) financial barriers including access to health insurance, (2) communication dynamics including those between the patient and family, the patient and the provider, and the family and the provider and (3) quality issues associated with cultural differences. A greater understanding of the cultural differences coupled with increased cultural awareness would aid in the delivery of more efficient and appropriate care for Mexican origin elders.

Session 3. Health Insurance and Access to Acute and Long-term Care Services among Hispanics

Latino Elderly and Health Insurance

Barriers and Health Outcomes

Rogelio Saenz, Mercedes Rubio

Access to health care is an increasing problem in the United States, especially among people of color, the poor, and the elderly. The Latino population, in particular, has especially elevated needs for health insurance. This paper focuses on the health insurance needs of the Latino elderly population, identifying the barriers to health insurance and health outcomes associated with the lack of health insurance. Data from the first and fourth waves of the Hispanic Established Populations for Epidemiological Studies of the Elderly are used to conduct the analysis. The first part of the analysis uses logistic regression to examine the role of nativity (including length of residence in the U.S.), gender, and socioeconomic status (SES) in the procurement of health insurance in waves 1 and 4. The second part of the analysis uses multiple regression and logistic regression to examine the association between the possession of health insurance at wave 1 and health outcomes and survival at wave 4, respectively. The paper concludes with a discussion of the implications of the results for public policy related to the health and health care needs of Latino elderly.

Session 3. Health Insurance and Access to Acute and Long-term Care Services among Hispanics

Closing Keynote Speaker

Ronald J. Angel

The majority of health care for families in the United States is paid for by employer-based group health insurance plans. Individuals and heads of household who are not employed in jobs that offer group coverage have few other options. Children, the disabled, and pregnant women in low income households have access to public programs, but these do not provide comprehensive or continuous care for all family members. Vulnerabilities in the labor force, then, translate directly into vulnerabilities in terms of access to adequate health care. Although Hispanics have high employment rates, they are disproportionately employed in service sector jobs that do not offer retirement or health benefits. Current debates on the future of the Nation's system of health care financing are particularly salient to Hispanics. These proposals range from market based changes that basically continue to status quo, to a fully publicly funded universal health care system. Proposals such as medical savings accounts may help some Hispanic families at the margin but they will be of little use to the majority of families that are currently incompletely insured. Employer or worker subsidies could extend coverage to a significant fraction of uninsured Hispanics, especially if they were mandatory. Universal coverage, of course, promises to cover all of those who are currently uninsured, but faces the most serious political opposition. This presentation deals with the positive and negative aspects of the major proposals for reform as they relate to Hispanics.

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Graduate and Post-Doctoral Student Poster Session

Poster Abstracts

Second Conference on Aging in the Americas
Key Issues in Hispanic Health and Health Care Policy Research

Presider and Chair
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Handgrip Strength and Cognitive Decline in Older Mexican Americans.

Ana Alfaro-Acha, Soham Al Snih, Mukaila A. Raji, Kyriakos S. Markides, Kenneth J. Ottenbacher

Background

Cognitive decline and dementia are associated with disability and premature death in older age. We examined whether lower handgrip strength predicts subsequent cognitive decline in older Mexican Americans.

Methods

A 7-year prospective cohort of 2,160 non-institutionalized Mexican Americans men and women aged 65 years and older residing in the Southwestern United States and who had a Mini Mental State Examination (MMSE) ≥ 1 at baseline from the Hispanic Established Population for the Epidemiological Study of the Elderly (H-EPESE). Measures included socio-demographic factors (age, sex, education, marital status), Mini Mental State Examination-MMSE, handgrip strength, body mass index (BMI), medical conditions (stroke, heart attack, diabetes, depression, and hypertension), and near and distant visual impairment.

Results

Using general linear mixed models we found a significant trend with scores in the lowest quartile of handgrip strength at baseline to be associated with lower MMSE scores at follow-up (Estimate = -1.28, SE = 0.16; $P < .0001$). There was a significant handgrip strength-by-time interaction with MMSE scores. Subjects in the lowest handgrip strength quartile had a greater cognitive decline over time (Estimate = -0.26, SE = 0.07; $P < .001$) than those in the highest quartile. This association remained statistically significant after controlling for potential confounding factors.

Conclusion

Older Mexican Americans with reduced handgrip strength at baseline demonstrated a statistically significant decline in cognitive function over a 7-year period. By contrast, subjects in the highest handgrip strength quartile maintained a higher level of cognitive function over the time.

Body Mass Index and Seven-year Incidence of Disability and Mortality Among Older Mexican Americans.

Soham Al Snih, Kyriakos S. Markides, Laura A. Ray, Kenneth J. Ottenbacher, James S. Goodwin.

Objective

To examine the relationship between body mass index and seven-year incidence of disability and mortality among older Mexican Americans.

Methods

A seven year prospective cohort of 3,050 non-institutionalized Mexican Americans aged 65 and older residing in the Southwestern United States. Measures included demographic, medical conditions (arthritis, diabetes, heart attack, stroke, cancer, and hip fracture), depressive symptomatology, hand grip strength, activities of daily living (ADLs), mobility tasks, an eight-foot walk test, and body mass index (< 20, 20 to < 25, 25 to < 30, 30 to < 35, 35 to < 40, and ≥ 40 Kg/m²). Cox proportional regression analysis was used to estimate the hazard ratio of seven-year incidence of disability and mortality.

Results

Of the 3,050 subjects, 1,815 reported no limitation in ADL activities and no limitation in mobility tasks at baseline. At the end of follow-up 939 subjects were deceased. Increased risk for any ADL limitation and any mobility limitation, after controlling for all covariates was found in subjects with a body mass index (BMI) ≥ 40 Kg/m²; the hazard ratio (HR) was 2.05 (95% CI, 1.01-4.17) and 2.03 (95% CI, 1.26-3.27), respectively. Subjects with a BMI of 25 to < 30 Kg/m² and a BMI of 30 to < 35 Kg/m² had a decreased risk for mortality; the HR was 0.83 (95 % CI, 0.69-0.99) and 0.72 (95 % CI, 0.57-0.92), respectively.

Conclusions

Older Mexican Americans with high BMI (≥ 40 Kg/m²) are at higher risk for development of disability over time, however high BMI was not associated with mortality in this population.

Quantifying Reliability and Predictors of Recording Diabetes Mellitus in Death Certificates Among a Mexican-American Cohort Study

The Sacramento Area Latino Study on Aging (SALSA) Study.

Vivian Colón López and Mary N. Haan

Death certificates are widely used to establish cause of death in epidemiologic, clinical investigation and national statistics. However, inaccuracy in death certification, discrepancies of race classification or the exclusion of critical diseases that contribute to death, will lead to unreliable mortality statistics that can under or overestimating the burden of the disease. To examine the reliability and predictors of recording diabetes mellitus over a 5-year period, death certificates from the descendants of the SALSA study were analyzed. According to the death certificates, 6.7% of the SALSA cohort is not of Hispanic or Latino origin. Diabetes mellitus was moderate recorded on the death certificates ($\hat{I}= 0.53$) even when the majority of the descendants have more than 15 years with the diabetes. Descendants with heart diseases (OR=2.53 95%CI:1.38,4.66) and renal disease (OR=3.17 95%CI: 1.30,7.72) as causes of death are more likely to have diabetes recorded on the death certificate than those without this diagnosis after adjusting for age at death. According with information obtained from baseline, self-report of kidney failure (OR=2.41 95%CI:1.17,4.96), myocardial infraction (OR= 2.37 95%CI:1.15,4.86), heart failure (OR=3.20 95%CI:1.22,8.41), smoking (OR= 4.79 95%CI:1.36,16.83) and more than 20 years diagnosed with diabetes mellitus (OR= 4.80 95% CI:2.22,10.38) were predictors of recording diabetes on the death certificate. Neither gender, place of birth nor other complication of diabetes such a glaucoma influenced mention of diabetes on the death certificate. Using death certificates to assess diabetes mortality gives rise to artifactual observations, underascertainment and incorrect statements of advance mortality especially among the Hispanic group.

Ethnic Disparities in the Utilization of Post-Acute Nursing Home Skilled Services

Michael Gerardo

Previous research suggests Hispanics, as compared to non-Hispanic whites, are less likely to use nursing home care. However, we know little of the relative use of post-acute care between Hispanics and non-Hispanic whites. To address this, we examined the rate of Skilled Nursing Facilities (SNF) admissions for Hispanics and non-Hispanic whites using the national repository of the Minimum Data Set (MDS). Using a linked MDS-Medicare inpatient claims file for 2000, we calculated the SNF admission rate per persons 75 years of age and older for each state. The numerator is the number of people with a SNF admission and the denominator is the population in that state age 75 and older based on the 2000 Census. In 2000, the age sex adjusted rate of SNF admissions for Hispanics was lower when compared to non-Hispanic whites (17.8/1000 for Hispanics compared to 32.8/1000 for non-Hispanic Whites). Of the 501,839 nursing home admissions, 89% were non-Hispanic white and 2% Hispanic residents. When the sample was constrained to those states where Hispanics represent greater than 4% of the 75+ population, the SNF admission rate was consistently less for the Hispanic population. Consistent with literature on differential use of nursing home care, Hispanics had a lower SNF rate after adjustment for age and gender.

Family Composition and Well-Being Among the Urban Elderly in Latin America

Maren Jiménez

Latin American researchers have long recognized the role of the households as a basis for pooling scarce resources and mitigating poverty. In countries where there is an underdeveloped social welfare net, the family is the main source of support and care, particularly for the elderly. Thus, it can be expected that extended household structures among the elderly are more likely to occur in countries with undeveloped welfare systems and low levels of savings—both of which are characteristic of many Latin American nations. Furthermore we can hypothesize that the presence of additional family members has beneficial effects on the well-being of the elderly. The empirical evidence for this hypothesis, however, is mixed.

Using data from the Health, Welfare and Aging in Latin America and the Caribbean (SABE) study, I examine the effects of marital status and household composition on the wealth and health of the elderly in three Latin American cities: São Paulo (n=2,143), Santiago (n=1,875), and Mexico City (n=1,875). My aim is to uncover how family characteristics are predictive of subjective well-being among older adults. Preliminary results indicate the strong deleterious effects of marital disruption on economic well-being, as well as the salubrious effects of living in extended households. However, results vary significantly by city. For instance, in Santiago, living with a child greatly increases the probability of an older adult rating their health as very good or excellent, yet household composition has no effect on self-rated health in the other two cities.

A Binational Study of Self-Assessed Health as a Predictor of Mortality

Jennifer Tovar

Self-assessed health has been used as a determinate of actual physical health in many studies in the United States. Debate has been generated with respect to such a measure's accuracy in depicting actual health across cultures, languages, and social circumstances, particularly among Mexicans. This study will attempt to address some of these issues by comparing older Mexicans in the United States to those in Mexico. The primary purposes of this paper are therefore to determine 1. if self-assessed health is a predictor of mortality binationally for Mexicans and 2. what factors may influence this relationship in terms of socioeconomics and migration. This study utilizes the Mexican Health and Aging Survey (MHAS) and The Hispanic Established Population of Epidemiologic Studies of the Elderly (Hispanic EPESE) to predict mortality before Time 2 (MHAS 2003, Hispanic EPESE 2002) by self-assessed health at Time 1 (MHAS 2001, Hispanic EPESE 2000) of Mexicans. Preliminary results reveal that twelve percent of the Hispanic EPESE sample and ten percent of the MHAS sample died between Time 1 and Time 2. With respect to self-assessed health, 79.3 percent from the United States and 63 percent of the Mexican sample who died before Time 2 reported fair or poor health. Multiple logistic regression results demonstrate that controlling for demographic characteristics and other socioeconomic variables, self-assessed health does predict mortality (with a slightly greater effect in the United States). Part of the effect of self-assessed health on mortality can be explained by body mass index for the sample in the United States. In Mexico however, the effect of self-assessed health on mortality is influenced by marital status, but this result is offset by body mass index. Since body mass index is an important measure of actual wellbeing, self reports of health by older Mexicans in the United States and Mexico may be a reliable tool for future health research of this population.

The Effect of Social Security Contributions on Wages The Colombian Experience

Andres J. Vargas

In this paper I use a difference-in-difference approach to estimate the effect of social security contributions on wages and how it varies across demographic characteristics. To do this I use the Colombian social security reform of 1993 that transformed the institutional framework for pension funds and health care provision. The reform meant an increase of 8.14 and 2.37 percentage points in the contributions, for firms and workers correspondingly, and an improvement in the quality and quantity of the benefits. My results show that an increase of 8.14 and 2.37 percentage points in social security contributions, for firms and workers correspondingly, reduced formal workers monetary compensation by 2.3%. The effect is mostly explained by the increase in pension contributions and varies across demographic characteristics as follows: First, for females the higher contributions reduced wages in the formal sector by 4.3%, while it did not have a statistically significant impact on the wages of male workers. Second, the effect of the reform is significantly different from zero only for young workers, generating a 3% reduction on their wages. Third, the increase in the social security contributions significantly reduced the wages of single workers in the formal sector, especially females with a negative effect of 4.4%, while the effect was not significantly different from zero for married employees. These variations are explained by the dissimilar valuations of the benefits received through social security different demographic groups have. Finally, the reform increased the relative wages of formal low-skilled workers by 6.4%, while it reduced the wages of their high skill counterparts by 3.2%. This result highlights the role of downward rigidities in wages due to the presence of a binding minimum wage, and the fact that underprivileged workers have a very high opportunity cost of social security contributions.

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