Aging and Health: Hispanic American Elders
Second Edition

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SGEC Working Paper Series
Number 5
Ethnogeriatric Reviews

Supported by a grant from the Bureau of
Health Professions for Geriatric Education Centers.

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PREFACE TO THE SECOND EDITION

This second edition of the review of the published literature relating the health of the older Hispanic population in the United States is presented by the core faculty and staff of the Stanford Geriatric Education Center (SGEC). We were pleased to have Dr. Maric Luz Villa, a geriatric physician, take the leadership in updating the review originally developed by Dr. Jose Cuellar, an anthropologist. We hope and expect that the combination of clinical and ethnographic insights will make this edition even more useful for the large number of geriatric educators in need of reliable material on elders from Latino backgrounds.

Since the first edition of the Hispanic review was completed in 1990, the ethnogeriatric literature has multiplied dramatically, and the number of articles appearing in peer-reviewed journals has grown substantially. It is heartening to see the recognition of the importance of the topic, but somewhat challenging to collect and summarize all the relevant pieces of this constantly increasing body of knowledge. The current edition reflects our effort to capture all the available material through the end of 1992, with some articles from 1993 also included. The authors would like to express our special appreciation to our SGEC Information Specialist Merry Lee Eilers, MA, whose devotion to accessing and referencing all the available material in an orderly fashion has made our efforts much easier and more dependable.

The second editions of the other three SGEC reviews for elders from American Indian/Alaska Native, African American, and Asian/Pacific Island backgrounds will be available during the coming year. It is our hope that these reviews of the health issues faced by elders from different ethnic backgrounds in the U.S. will be helpful in filling the gaps in knowledge and materials for educators and researchers interested in ethnogeriatrics. If there are suggestions for making them more helpful, please let us know.

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November, 1993

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PART I

INTRODUCTION

Issues concerning older Hispanics generally have been ignored in the health literature of the past three decades, but recently interest in health care of elders with various ethnic backgrounds (ethnogeriatrics) has been increasing. The number of available publications on Hispanic elders has grown dramatically from the first report of aging Spanish speakers in the southwestern U.S. in the late sixties (Leonard, 1967) to the current collection of over 800 known references relating to health alone, contained in the Stanford Geriatric Education Center’s (SGEC) computerized Bibliographic Data Base in Ethnogeriatrics. The national gerontological and geriatric organizations increasingly include papers on issues related to health of older Hispanic Americans in their annual meetings, and have created special committees or task forces to attend to issues of the health of minority elders, spurred to some extent by an Administration on Aging sponsored initiative on minority aging in 1988. The National Institute on Aging and a number of other foundations have developed initiatives specifically related to research on Hispanic elders, so the future looks bright for a continued expansion of information on geriatric care for older Hispanics.

This paper reviews the available published literature on health-related research among older members of the population in the United States classified as "Hispanic," one of the four federally recognized ethnic minority categories used for reporting data. The purpose is to draw implications for those health professionals and para-professionals who need to provide competent care that integrates racial and cultural variations among Hispanic elders. It represents the interpretations and perspectives of the authors and other members of the multidisciplinary, multiethnic SGEC Core Faculty.

"HISPANIC" AS A CATEGORY

"Hispanic" generally is defined as having a Spanish surname, being Spanish-speaking, or originating from a Spanish-speaking country. This classification refers to a heterogeneous population of individuals from numerous ethnic groups who vary markedly in their unique demographic characteristics and geographic distribution in different parts of the U.S. These groups include sizable proportions of post-World War II immigrants who are highly concentrated in urban areas and are predominantly of low economic status (Giachello, Bell, Aday, & Anderson, 1983; Hayes-Bautista, 1983).
Also included are rural populations whose ancestors came to what is now the U.S. Southwest long before the Anglo invasion of that territory, as well as assimilated and acculturated urban families, many of whom work in professional occupations.

"Hispanic" is a problematic label that glosses over the salient national, ethnic, and racial variations of a population with significantly varied histories and perspectives. Geriatric care providers need to know that some older Hispanics are native-born U.S. citizens, others are documented permanent resident immigrants, others are undocumented temporary migrant workers, and some are documented or undocumented refugees from various Latin American countries. These differences alone account for more significant politico-economic and psycho-ecological variations among aging U.S. Hispanics than most analysts care to consider.

The indiscriminate use of the "Hispanic" label without additional ethnic qualifiers creates problems for both secondary interpretations and comparative analyses. Moreover, it reduces confidence in generalizations and recommendations made from one population to the next. Indeed, some studies have combined U.S. Hispanics with Blacks, and sometimes Asians and American Indians, in a "non-white" minority category for the purposes of comparison with the "white" majority population. In other studies, Hispanics are categorized as "white" but distinguished ethnically by Spanish surname or language. As a consequence, some of the existing data are often misleading, if not erroneous.

The U.S. census currently specifies that Hispanics can be of any race, but prior to 1980 they were usually included in the "white" category. Since a portion of immigrants to the U.S. from Central and South America and the Caribbean would be categorized racially as "black" in the U.S., the confounding effect of overlapping racial and ethnic categories can cause significant analytic problems. This is a particular issue in those studies where genetic factors may contribute, such as risk for diabetes. Since the largest Hispanic population in the U.S., those of Mexican descent, have been found to have a 20 to 50 percent American Indian genetic admixture (Stern & Haffner, 1990), combining all of the Hispanic populations in analyses sensitive to racial heritage could obscure potentially important effects.

Given the historical, cultural, political, social, and genetic diversity within the group categorized as "Hispanic," continued use of this problematic label reflects preference by individuals in the federal bureaucracy in key decision making positions (Choldin, 1986; Tienda & Ortiz, 1986). In spite of the problems, this review and the other three in the SGEC ethnogeriatric review series use categories consistent with federally reported data, since much of literature reflects those divisions. In this paper, "Hispanic" is used when discussing: (1) national data sets that include several diverse groups on the basis of Spanish language or surname; (2) comparative research that deals with two or more specific Hispanic ethnic groups; or (3) research that fails to give specific ethnic qualifiers. Otherwise, ethnic specific identifiers will be used.
Similarly, confusion abounds when comparing Hispanics and non-Hispanics: both can be members of the same racial group, and the distinction strived for is often an ethnic one. Most studies that compare Hispanics and non-Hispanics exclude Blacks and Asians, so that the subject groups are all Caucasian. Furthermore, non-Hispanic Caucasians are variably referred to as "Anglo" or "white." In this review of Hispanics, therefore, we will distinguish Hispanic and non-Hispanic Caucasians by referring to "Hispanics" and "Anglos," respectively.

Acculturation may be thought of as the extent to which a minority group adopts the customs, diet, language, behaviors, and values of the mainstream population. In addition to affecting disease prevalence, the level of acculturation and its associated life style choices may indirectly modify health outcomes. For example, epidemiological studies reveal that Mexican American women tend toward obesity and point out that body image is largely culturally defined (Stern, Rosenthal, Haffner, Hazuda, & Franco, 1984). As the findings on health are presented, it is important to keep in mind the wide range in levels of acculturation found among Hispanic elders in the U.S. and the implication of those differences. Where acculturation studies are available, they are reported in this review.

A BRIEF HISTORY OF HISPANIC ETHNOGERIATRICS

The focus on Hispanic aging as a scientific concern or social problem emerged relatively recently. Hispanic aging began attracting the serious attention of researchers and policy makers in the U.S. only in the early 1970s. This change appeared primarily as a response to concerted advocacy efforts by Chicano and Puerto Rican activists in the field of aging, rather than out of scientific interest.

The following circumstances also stimulated concern about the conditions of older Hispanics: (a) the explosion of predominantly Spanish-speaking populations in the U.S. during the 1960s; (b) an increased visibility of older Mexicans, Puerto Ricans, and Cubans; (c) the effects of urbanization or "barrioization" (the increased concentration of Mexicans, Puerto Ricans, Cubans, and others in identifiable urban neighborhoods or districts); and (d) the increasingly widespread sociogeographic mobility of the Mexican and Puerto Rican populations from coast to coast. These conditions raised questions regarding whether elders still expected to live in an extended family, or to be supported by adult children when in need. Poverty, along with an apparent lack of access to resources, caused even casual observers to see the aging of Mexicans, Puerto Ricans, and Cubans in the U.S. as a potential social problem.

Consistent with this social view of the problems of a rapidly growing population of aging Mexicans, Puerto Ricans, Cubans, Central Americans, and others in the U.S., the focus of most research until the late 1980's continued to be on those factors.
associated with the adaptations and adjustments of this population to changes and discontinuities that may be disruptive and detrimental to their lives. The research clearly shows a great concern with such issues as health and life satisfaction after retirement, morale and familial support, isolation of immigrants, and well-being (Cuellar & Weeks, 1980; Jorgenson & Santos, 1985; Liang, Tran, & Markides, 1988; Markides, Boldt, & Ray, 1986; Markides, Saldana Costley, & Rodriguez, 1981; Weeks & Cuellar, 1981, 1983). Consistent with the social welfare orientation that has characterized gerontology since its beginnings, the ethnogerontology of Hispanics has focused attention on issues of access to available health and human services, and on the barriers that prevent equitable utilization. More recently increasing attention has been given to other conditions of aging, particularly health issues in later life. Although much of this recent research has focused on how health as an intervening variable affects retirement, morale or other aspects of aging, research initiatives on Hispanic aging such as those funded by National Institute on Aging and other federal and private agencies are resulting in a growing body of literature on epidemiological and clinical issues of great applied interest to geriatric health care providers.

It is important to note that while this paper surveys the subfield of ethnogeriatrics related to Hispanic aging and health, the results actually reveal the rather uneven nature of the present state of knowledge on the subject. Though the body of literature has grown significantly during recent years, there is still much more information and understanding about aging Mexican Americans than about aging Puerto Ricans and Cubans in the U.S., the other two larger groups, and almost nothing about Salvadoreans and other demographically smaller, predominantly Spanish-speaking segments of the aging U.S. population.

PART II

DEMOGRAPHIC CHARACTERISTICS¹

POPULATION SIZE AND TRENDS

Of the estimated 20.8 million documented and undocumented individuals classified as Hispanic in the U.S., about 5% are 65 years and older. These elders comprise 4% of the U.S. older population, according to the 1990 census (Fowles, 1991). Of the approximately one million Hispanic elders in the U.S. in 1989, 48% were

¹Unless otherwise noted, all statistics in this section are from Lopez & Aguillera, 1991. Sources of information used in that report include unpublished data from the 1990 census, data from a 1988 census published in March 1989, and data from a 1987 Westat survey of elderly Hispanics commissioned by the Commonwealth Fund.
of Mexican descent, 18% were of Cuban descent, 11% Puerto Rican, 8.4% Central and South American, and 15% other Hispanic. (According to Curiel and Rosenthal, 1988, "other Hispanics" represent persons primarily from New Mexico who designate themselves as Hispanic or Hispanos.) In 1988 58.4% of older Hispanics were female.

In the 1980’s, the Hispanic population jumped by 52% to account for 9% of the U.S. population. Half of this increase was due to immigration. In California, New Mexico, and Texas, over 25% of the population consider themselves Hispanic (U.S. Department of Commerce, Bureau of the Census, 1991). The U.S. Hispanic population is a young population, with a median age of 25.9 in 1989 compared to 32.5 years for the total U.S. population. As this population ages over the next decades, the proportion of Hispanic elders is expected to increase dramatically. From the years 2000 to 2050, the population of elders in the country is expected to nearly double, while the population of Hispanic elders is expected to more than quadruple. Thus, while in 2000 Hispanics are expected to be 4.9% of the nation’s elders, by 2050 they are expected to be 11.5% of all elders.

There are differences in the age compositions of Hispanic ethnic groups. Mexicans are the youngest group with a median age of 23.6, followed by Puerto Ricans with a median age of 26.8, and Central and South Americans with a 28.4 years median age. Cubans are the oldest group with a median age of 41.4. The Cuban population has a slightly higher proportion of persons 65 and over than the total U.S. population (17% versus 12%); compared to 4% for Mexicans, 5.5% for Puerto Ricans, and 2.8% for Central/South Americans in the U.S.

To some extent, the variance in median age between Hispanic ethnic groups reflects immigration patterns but also differences in fertility rates. U.S. Mexicans and Puerto Ricans have much higher birth rates than U.S. Cubans and Central/South Americans, and the fewer the number of children, the greater the percentage of older adults in a population. Thus, the population surge among older Hispanics, particularly those of Mexican and Puerto Rican descent, is masked to some extent by the even greater explosion at the younger end of the age structure. This is important because the combination of lower median age and smaller proportion of elders in Mexican and Puerto Rican populations sometimes confuses analysts into thinking that the numbers of older Mexicans and Puerto Ricans are growing at a more modest rate than are populations that have lower fertility rates (Markides & Mindel, 1987).

GEOGRAPHIC DISTRIBUTION AND URBANIZATION

Though there are Hispanic elders in every state of the nation, in 1987 they were primarily distributed in the South (39%) and West (34%). According to 1980 data, more than 70% of Hispanic elders live in only four states: California (25%), Texas (21%), Florida (13.5%), and New York (11%). Like the total U.S. Hispanic population,
aged Hispanics are more urbanized than other categories of older persons in the U.S.. In 1987, 91% lived in metropolitan areas, compared to 83% of older Blacks, and 72% of older Anglos. The largest concentrations of older Hispanics are in the Los Angeles-Long Beach, California megalopolis; followed by New York-New Jersey; Miami, Florida; Chicago, Illinois; San Antonio, Texas; Houston, Texas; El Paso, Texas; and the Riverside-San Bernardino-Ontario, California areas. These findings are important because they help dispel misconceptions that older Hispanics, especially Mexicans, are predominately rural. In fact, these are aging individuals adapting to rapidly changing urban environments. The literature suggests that older segments of a population are the least likely to move; compared to older Cubans, Puerto Ricans, and other Hispanics, the data suggest that older Mexicans remain the least geographically mobile. A national survey found that almost one in four (24%) had lived in the same neighborhood for 36 years or more, with the majority living in the same house for more than six years (Lacayo, 1980).

Contrary to assumptions held by many, data from the 1980 Census show that 57% of Hispanic elders were born in the U.S.. A large proportion of Mexican American elders are from families who have lived in the U.S. for generations. Geriatric care providers need to anticipate that future cohorts of aging Mexican Americans will probably include increasing proportions of native-born citizens and long term residents, as well as elders who have migrated from Mexico at later ages to join children already living in the U.S., or so called "followers of children."

GENDER, MARITAL STATUS, AND LIVING ARRANGEMENTS

In 1990, the ratio of males for each 100 females aged 65-74 was 100 among Puerto Ricans and Mexican Americans and 91 among other Hispanics. (Among Anglos the comparable ratio is 81.) As a result of gender differences in survival probabilities, the ratio drops to about 70 for all Hispanics aged 75 and over (Angel & Hogan, 1991).

As noted in Table 1 below, the marital status of Hispanic elders is similar to that of most older Americans, although there are small differences reported in some categories. Namely, a higher proportion of older Hispanic men are separated, more women are divorced, and fewer women are widowed.

Hispanic elders are less likely to live alone and more likely to live with other family members, particularly in a multigenerational family where an adult child is the householder. In 1989, over 75% of Hispanic elders lived with other family members, compared to 67.5% of Anglo elders and 63% of black elders (Lopez & Aguilera, 1991). Older Hispanic males and females are four times as likely as Anglos between 65 and 74, and more than twice as likely as those 75 and older, to live with their adult children; Hispanic males are more likely to head their own households even in later life.
Table 1

MARITAL STATUS OF HISPANIC AND TOTAL POPULATION
65 AND OVER IN U.S.

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Hispanic Origin</th>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Never married</td>
<td>6.6%</td>
<td>8.2</td>
</tr>
<tr>
<td>Married, spouse present</td>
<td>65.6%</td>
<td>37.6</td>
</tr>
<tr>
<td>Married, spouse absent</td>
<td>7.7%</td>
<td>2.5</td>
</tr>
<tr>
<td>Widowed</td>
<td>15.1%</td>
<td>43.6</td>
</tr>
<tr>
<td>Divorced</td>
<td>5.0%</td>
<td>8.1</td>
</tr>
</tbody>
</table>

Adapted from U.S. Senate Special Committee on Aging et al. (1992). p1.84, based on census data.

(Cubillos, 1987). Thus, it is not surprising to find that only 3% of all Hispanic elders were reported living in nursing homes, including only 10% of those 75 and older, compared to 23% of non-Hispanic whites over 75 (Cubillos, 1987).

Elders who live in extended family households, especially those over the age of 75, are more likely to be widowed women (Cubillos, 1987). Burr and Mutchler (1992) analyzed data for unmarried (widowed, divorced, and never married) Hispanic females 55 and over from the 1980 census to test a conceptual framework on cultural preferences for living arrangements. They found that about a third of these women from all Hispanic ethnic origins lived alone, compared to 59% of similar Anglo women. Cuban women were more likely to live with others, not as head of the household, than those from Mexican, Puerto Rican and "other Hispanic" backgrounds, who were about equally as likely to be heads of a household as not. When analyses controlled for age, marital status, availability of kin, personal income, education, disability status, immigration status, and language proficiency, the Hispanic women were more similar to Anglo women in the likelihood of living alone, but differences still existed. The authors concluded that the most important contributors to the differences in living arrangements seemed to be the national origin groups, culturally defined desirability, and, to a lesser extent, availability of kin. In relation to the latter factor, it is interesting to note the differences in average number of children ever born to these women, which were: 4.1 for Mexican American, 3.8 for Puerto Rican, 2.1 for Cuban American, 3.1 for "other Hispanic," and 2.2 for non-Hispanic white.

LANGUAGE, LITERACY, AND EDUCATION

The most obvious shared characteristic of older U.S. Hispanics is language preference. The National Needs Assessment Study (Lacayo, 1980) found that 86% of the respondents chose to be interviewed in Spanish, and when asked which language
they used most of the time, 94% of the older Cubans, 91% of Puerto Ricans, 86% of Mexicans, and 76% of other older Hispanics reported that they speak Spanish most of the time. Only 10% of all older Hispanics reported speaking English at home.

Limited English proficiency has been identified as a barrier to services and benefits in the wider society, and in 1989, 39.3% of Hispanic elders (32% of Mexican American and 37% of Puerto Rican elders) reported that they did not speak English at all. Fifty-seven percent of all older Hispanics reported speaking English. However, estimates are that more than half of older Hispanics are functionally illiterate in both Spanish and English, due to low educational attainment. In addition to difficulty in communicating with physicians, pharmacists, and other health providers, (Kail, 1989), Spanish language preference and lack of English proficiency predict low exposure to media-based health information (Ruiz, Marks, & Richardson, 1992).

A good education is one of the least common characteristics of older Hispanics in the U.S.. In 1990, only 16% of Hispanic elders had completed high school, compared to 60% of older Anglos. The median educational attainment of Hispanic elders was eighth grade (American Society on Aging, 1992). Hispanic elders also had a lower percentage of college graduates in 1988 (4.1%) than Anglo (11.1%) or black (4.7%) elders.

The obvious implication for geriatric health providers and educators is the need to develop health education strategies for older Hispanics, especially Mexican American and Puerto Ricans, that rely less on written formats and more on other forms of communicating and transmitting information. Similarly, an effort by non-Spanish-speaking providers and educators to learn the Spanish language and culture would dramatically increase the effectiveness of communication.

EMPLOYMENT, INCOME, AND RETIREMENT

Employment information on older Hispanics is very limited, but according to 1989 data, older Hispanics are more likely than older Anglos and non-Hispanic Blacks to report being unemployed, although they have an almost identical labor force participation rate (11.4%). Among older Hispanics, Puerto Ricans are least likely to be in the labor force, and Cubans are the most likely. Older Puerto Ricans are more likely than older Mexicans or Cubans to report that they are unable to work (Cubillos, 1987; Lacayo, 1980; Perrault & Raiford, 1983).

Historically, a greater percentage of older U.S. Hispanics, particularly Mexicans and Puerto Ricans, have spent their lives in low-paying manual labor or service occupations, rather than technical, sales, managerial, or professional occupations. In contrast, older Cubans have higher percentages of technicians, professional sales and clerical workers than the other groups. The current data suggest a continuation of this
pattern, with more than one third (36%) of employed older Hispanics holding service jobs, compared with fewer than one fifth (18%) of older Anglos who work. The pattern of lifetime employment in these low-paying positions results in insufficient Social Security benefits, pensions or health plans to sustain older Mexican Americans and mainland Puerto Ricans after retirement. A 1986 telephone survey in Dade County, Florida of elders aged 60 and over found that 91% of immigrant elders (predominantly Cuban) had coverage for Medicare Parts A and B, compared to 98% of non-immigrants. Only 36% of immigrant elders had additional health insurance (Siddharthan, 1991). While 33% of Anglo elders in 1988 received private retirement pensions, only 16% of Hispanic elders did so (American Society on Aging, 1992).

Old age is the reason older Hispanics, particularly Cuban Americans, most often give for retiring. The second reason, particularly for Mexican Americans, is poor health. Moreover, 56% of older Mexican Americans give poor health as the reason for not looking for work. Older Puerto Ricans retire due to the unavailability of work. The findings suggest that older U.S. Hispanics, particularly Mexicans, frequently retire before age 65 either due to poor health or lack of job opportunities. Contrary to stereotypes, aging U.S. Mexicans exhibit poorer adjustment to retirement than Anglos, as a result of their preference for work over retirement and their generally poorer economic conditions (Markides & Martin, 1983).

The 1990 poverty level for individuals 65 and older living alone was $6,268 and $7,905 for an older couple household. In that year the median income for older Hispanics living alone or with nonrelatives was $7,060, compared to $10,798 for Anglo elders and $6,308 for black elders. Thus, the median per capita income for older Hispanics was slightly above the poverty line. Twenty-two percent of Hispanic elders had incomes under the poverty level, based on census data (Fowles, 1991) as well as data collected in the 1988 survey of a representative sample of 2299 Hispanic noninstitutionalized elders by Westat, Inc. for the Commonwealth Fund Commission on Elderly People Living Alone (Andrews, Lyons, & Rowland, 1992). The median income for female Hispanic elders in 1989 was $5,543, compared to $8,486 for their male counterparts.

While Social Security is the income base of most older persons in the U.S., in 1988 fewer aging Hispanics (77%) were likely to receive benefits than Anglos (93%) or Blacks (89%). But those older Hispanics who did receive Social Security benefits were more likely to depend on them as their major or only source of income. In 1988, Social Security provided 64% or more of the total income for half of Hispanic elders, while it provided 48% or more of the total income for half of Anglo elders.

Due to low incomes and limited participation in Social Security and other retirement plans, Hispanic elders are more likely than other elders to depend on Supplemental Security Income (SSI) benefits. In 1988, 21% of Hispanic elders...
received SSI benefits, compared to 7% of all elders. Furthermore, it appears that only 44% of eligible (extremely low income) Hispanic elders receive SSI.

PART III
HEALTH STATUS
FUNCTIONAL STATUS AND SELF-RATED HEALTH

Most comparisons of functional status have shown Hispanic elders to be at a disadvantage compared to others in the U.S. An analysis of the data from National Health Interview Survey (NHIS) reported by Trevino and Moss (1984) compared functional status indicators of Hispanic and non-Hispanic populations, as well as among the Hispanic ethnic groups. Table 2 below presents these data as well as other evidence that Hispanic elders need more help with Activities of Daily Living (ADLs). In addition, employed Hispanic elders reported an average of 10.4 days per year lost from work, compared to 4.0 days for Anglo elders.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>All Hispanic</th>
<th>Mexican Am.</th>
<th>Cuban Am.</th>
<th>Puerto Rican</th>
<th>Anglo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restricted Activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days per Year</td>
<td>46.5</td>
<td>52.8</td>
<td>43.6</td>
<td>61.4</td>
<td>38.7</td>
</tr>
<tr>
<td>Bed Disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days per Year</td>
<td>20.7</td>
<td>26.1</td>
<td>17.6</td>
<td>35.7</td>
<td>12.9</td>
</tr>
<tr>
<td>% with Activity Limitation</td>
<td>47.0%</td>
<td></td>
<td></td>
<td></td>
<td>44.3%</td>
</tr>
<tr>
<td>% with Limitation in Major Activity</td>
<td>42.4%</td>
<td></td>
<td></td>
<td></td>
<td>37.6%</td>
</tr>
<tr>
<td>Needing Help with One or More ADL</td>
<td>19.0%</td>
<td></td>
<td></td>
<td></td>
<td>15.4%</td>
</tr>
</tbody>
</table>

Sources: 1=Trevino & Moss, 1984; 2=Lopez & Aguileras, 1991
A comparison of over 500 older Puerto Ricans from the New York city area with national samples of black and white elders found that Puerto Rican elders reported a much higher level of disability on personal care and mobility measures (O'Donnell, 1989). The disability was positively related to having difficulty with the English language.

A 1989 report by the House Select Committee on Aging found that, in 1986, 41.2% of Hispanic elders perceived themselves to be in poor or fair health, compared with 29.9% of all U.S. elders (Lopez & Aguilera, 1991). The survey of over 2000 Hispanic elders commissioned by the Commonwealth Fund found an even larger percentage (54%) reported fair or poor health compared to the 35% reported by all older Americans in the similar 1986 Harris poll (Andrews et al., 1992).

A caution is raised, however, in comparing self-reported health ratings between Hispanic and Anglo elders by Bastida and Gonzalez (1993). They found that in their sample only 2% of Mexican American and 1% of Puerto Rican elders rated their general health as excellent, and 23% and 27% rated it as good, respectively, compared to their Anglo sample in which 21% rated their health as excellent and 46% rated it as good, even though the Anglos were 10 years older and reported more chronic illnesses, medications, and hospitalizations. The number of bed disability days were comparable between the groups, and although arthritis was the most common condition reported by both Hispanic subgroups, the percentage was slightly lower than among the Anglos. The authors conclude that cultural perceptions of health may be responsible for some of the differences in self-rated health. A similar conclusion was reached by authors of a comparison of Cuban, black, and Anglo elders in Miami. They found that Cubans reported the least disability but the lowest self-assessed health ratings (Linn, Hunter, & Linn, 1980).

Some longitudinal data concerning predictors of well-being and functioning in older Mexican Americans (Markides & Lee, 1990) indicate that physical, psychological, and social declines are not as great with age as cross-sectional data would have predicted. The very old in this study were more likely to show declines in activity over time, and low education was associated with greater declines in health and mental health throughout the population studied.

Studies are available on two factors which frequently affect functional status, independence, and sense of overall health, which are hearing loss and hip fracture. Hearing loss in the Hispanic community parallels that of the overall aged population, with a higher prevalence in Mexican American men; use of hearing aids by elderly Hispanics, however, is low (Lee, Carlson, Lee, Ray, & Markides, 1991), a situation that may be related to access. Two hospital discharge studies indicate that Hispanic women are at lower risk for hip fracture than Anglo women, but Hispanic men have about the same risk as Anglo men (Bauer, 1988; Silverman & Madison, 1988).
Mortality and morbidity data for Hispanics following hip fracture are not available, nor have the reasons for differences in hip fracture incidence been elucidated.

MORTALITY

Research on morbidity and mortality of older Hispanics is growing rapidly but suffers from major limitations of inconsistency and incompleteness, due in part to the problem of difficult and inconsistent population identification in census and vital statistics records, as well as similar problems in research samples.

The earliest studies of U.S. Mexican mortality in Texas were based on identified Spanish surnames on death certificates; recognizing the potential inaccuracy involved (not all Mexicans in the U.S. have Spanish surnames, while some non-Mexicans do) the authors, nonetheless, concluded that age-adjusted death rates for Spanish surnamed males were very similar to the rates for non-Spanish surnamed males, but were approximately 19% higher for Spanish surnamed females than for non-Spanish surnamed females (Bradshaw & Fonner, 1978). Other analyses of 1970 life expectancy values for Spanish surnamed persons in Texas and California found the rates for both males and females to be closer to those of Anglos. A slight male "crossover" effect was found for Spanish surnamed males, who had higher mortality rates at younger ages and lower ones after age 45; a sort of "double crossover" was indicated for Spanish surnamed females who have higher mortality rates under 30, then lower rates to age 54, and then higher rates again at age 60 and older (Schoen & Nelson, 1981). Precisely why these "crossovers" occur is neither theoretically nor empirically apparent and needs more study, although it may be due in part to the cross-sectional nature of the data.

Although it is clear that older females tend to outlive and outnumber older males, it is not clear why older Hispanic females have higher mortality rates than older non-Hispanic white women. Some analysts have advanced variants of what might be called the "stress, wear, and tear" hypothesis, which has yet to be rigorously tested. Becerra and Shaw (1983), for example, suggested that Hispanic women age sooner and die younger because they are taxed by birthing and raising large numbers of children.

One study examined the 1979-81 mortality experience of the first generation in the three major U.S. Hispanic ethnic populations, as defined by place of birth (Cuba, Mexico, and Puerto Rico) (Rosenwaike, 1987). Compared to the other two groups, Puerto Rican mortality for both sexes was higher at all ages with two exceptions: children ages 5-14, and elders 75 and over (See Table 3). Among the three groups, Puerto Rican-born had the highest age-adjusted death rates and the Cuban-born had the lowest. These findings theoretically suggest that an inverse relationship between
socioeconomic status and mortality may account for some of the differences among these Hispanic populations, but more research is needed to confirm this hypothesis.

Beyond age 45, when one would expect to find increased mortality from obesity-related disorders, one study of Mexican Americans in Texas found that age-specific and age-adjusted all cause mortality was as good if not better in Mexican Americans than in Anglos (Stern, Patterson, Mitchell, Haffner, & Hazuda, 1990). This implies that tables of ideal weights may not be applicable to Mexican Americans in terms of identifying those at risk for obesity-related mortality. Prevalence estimates for obesity are based upon data gathered from the Second National Health and Nutrition Examination Survey (NHANES II) which used weights and heights of healthy, Caucasian, 20-29 year olds. Data from the Hispanic Health and Nutrition Examination Survey (HHANES, 1982-1984) indicate that 14% fewer Mexican American women would be classified as overweight if ethnic-specific weight/height standards were used (Lopez & Masse, 1992).

<p>| Table 3 |
| DEATH RATES OF OLDER ADULTS IN U.S. BORN IN CUBA, MEXICO, AND PUERTO RICO, COMPARED TO WHITES AND BLACKS, 1979-81 |
| (Average Annual Rates per 100,000) |
|</p>
<table>
<thead>
<tr>
<th>Age and Sex</th>
<th>Cuba Born</th>
<th>Mexico Born</th>
<th>Puerto Rico Born</th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55-64</td>
<td>1,145</td>
<td>1,090</td>
<td>1,729</td>
<td>1,718</td>
<td>2,821</td>
</tr>
<tr>
<td>65-74</td>
<td>2,847</td>
<td>3,250</td>
<td>3,441</td>
<td>3,992</td>
<td>5,022</td>
</tr>
<tr>
<td>75+</td>
<td>7,817</td>
<td>9,569</td>
<td>8,604</td>
<td>10,639</td>
<td>10,149</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55-64</td>
<td>538</td>
<td>684</td>
<td>844</td>
<td>869</td>
<td>1,534</td>
</tr>
<tr>
<td>65-74</td>
<td>1,460</td>
<td>2,047</td>
<td>2,152</td>
<td>2,037</td>
<td>2,967</td>
</tr>
<tr>
<td>75+</td>
<td>6,206</td>
<td>7,369</td>
<td>7,297</td>
<td>7,590</td>
<td>7,334</td>
</tr>
</tbody>
</table>

(Mortality rates for specific causes provide a more comprehensive picture. In the comparative mortality study by Rosenwaike (1987), Puerto Rican-born males had 20% higher rates of heart disease related deaths than the other two Hispanic subgroups, closer to the rate for Anglos; heart disease related deaths for Puerto Rican-born females were more than 45% higher than for Anglos and were closer to those for non-Hispanic black women. Although cardiovascular mortality is declining in...
this country, it is declining more slowly for Hispanics than for Blacks and Anglos and is still the leading cause of death for all older adults (Caralis, 1990). Data on younger age groups (45 to 65 years) in the San Antonio Heart Study and the San Luis Valley Diabetes Study indicate that despite a higher cardiovascular risk factor profile compared to Anglos, Mexican American men experience lower cardiovascular mortality rates. The same is not true for women. Although Mexican American women have a higher cardiovascular risk factor profile as compared to Anglos, they have the same cardiovascular mortality rate (Mitchell, Stern, Haffner, Hazuda, & Patterson, 1990; Burchfiel et al., 1990). In Los Angeles County, Hispanics have the second highest mortality from cardiovascular disease of the four ethnic minority categories, and are at high risk for hypertension-related morbidity and mortality (Haywood, 1990).

Rosenwaike’s data (1987) for age-adjusted mortality show that the Mexican-born population has the highest cerebrovascular disease mortality of the three major Hispanic groups, and the Cuban-born the lowest. On the other hand, Cuban-born Americans had the highest rate for malignant neoplasms, and the Mexican-born the lowest. Mexican Americans also had a marked excess of death due to accidents, with a rate approaching twice the level shown by the other two groups.

Age-adjusted cancer mortality for males and females born in Mexico was found in the 1970s to be higher than among Anglos for liver, stomach, pancreatic, and cervical cancers and lower for intestinal and rectal cancers (Lilienfeld, Levin, & Kessler, 1972). A more recent analysis found that the only major exceptions to the general pattern of lower cancer mortality among Mexican-born residents were (a) substantially higher mortality rates for Mexican-born males and females from stomach and liver cancers and (b) a mortality rate from cancer of the cervix that was twice that for U.S. white females (Rosenwaike, 1988).

Diabetes is a major problem among U.S. Hispanics, especially Mexicans and Puerto Ricans. The age-adjusted death rates due to diabetes were especially high among Mexican and Puerto Rican women, and appeared as the fourth leading cause of death for both groups, while the rates for Cuban women were lower even than those for Cuban males. In fact, the age-adjusted diabetes death rates among Cubans were only about half those of the other groups.

Compared to younger groups, aged migrants from Mexico, Puerto Rico, and Cuba in the Rosenwaike study (1987) exhibited relatively low death rates from heart disease and cancer. These findings appear consistent with the theoretical notion that the migration selection factor lowers the migrants’ overall mortality rate when compared with the prevailing rate in the country of origin. They also suggest that environment, genetic influences, and lifestyle (including diet, smoking, and drinking patterns) probably account for the substantially lower mortality rates of Mexicans, and especially Cubans, when compared with Puerto Ricans, Anglos, and Blacks. These findings are consistent with those of earlier studies in California and Texas, as well as
with a comparative study of Puerto Ricans and Mexicans in Chicago (Markides & Mindel, 1987; Shai & Rosenwaike, 1987).

The most distinctive mortality pattern for Puerto Ricans in the age-adjusted death rates in the cross-ethnic studies was due to chronic liver disease and cirrhosis, a leading cause of death among heavy users of alcohol (Rosenwaike, 1987). It was twice that among Mexicans and nearly three times that of Cubans in the U.S. The mortality rates due to homicide were exceptionally high among males in all three groups, particularly Puerto Ricans. Although suicide was highest among Cuban and Puerto Rican males, suicide rates were particularly low among females in all three groups, especially Mexicans. A five-year comparison in five southwestern states found that older Hispanic males had suicide rates that were less than half that of Anglo males (28 per 100,000, compared to 63) and rates for older Hispanic females were less than one third of their Anglo counterparts (Smith, Mercy, & Warren, 1985).

A leading cause of death among older Mexican Americans may be "symptoms, signs, and ill-defined conditions," a category of cause of death listed in the Manual of the International Classification of Diseases, Injuries, and Causes of Death (Becker, Wiggins, Key, & Samet, 1990). In New Mexico, age-adjusted death rates for deaths attributed to symptoms, signs, and ill-defined conditions were higher for Hispanics than for Anglos, especially for persons 75 years of age and older, a finding that could strongly bias studies of cause-specific death rates that rely on death certificate data. It is postulated that the increased use of this death category may be due to lack of access to health care among the economically disadvantaged and/or avoidance of conventional modern medical care.

**MORBIDITY**

**Diabetes.** As already noted, diabetes is a significant source of morbidity among older U.S. Hispanics. The prevalence of non-insulin-dependent diabetes mellitus (NIDDM) in Mexicans and Puerto Ricans is approximately two times greater than in Anglos, whereas Cubans have a much lower prevalence, only slightly higher than that of Anglos (Harris, 1991; Stern & Haffner, 1990). This pattern is interesting because U.S. Mexicans have a significant degree of American Indian ancestry, whereas Puerto Ricans have significant degrees of both American Indian and African American ancestry (Hanis, Hewett-Emmett, Bertin, & Schull, 1991). The prevalence of NIDDM appears to decline with increasing levels of acculturation (Hazuda, Haffner, Stern, & Eifler, 1988), which may reflect increasing admixture of genes in more acculturated individuals and/or changes in dietary patterns and obesity. A higher prevalence of insulin resistance in non-diabetic Hispanics has also been observed, even after adjustment for age and obesity (Haffner, Stern, Hazuda, Pugh, & Patterson, 1986). In addition to higher rates of NIDDM and obesity in Mexican Americans compared to Anglos, there is a marked elevation of triglycerides among Mexican Americans in both sexes and reduced levels of high-density lipoproteins in females, a pattern similar to
the lipoprotein profile seen among the Pima Indians (Hanis, Hewett-Emmett, Douglas, & Schull, 1991).

The prevalence of diabetes increases with age. In the San Antonio studies, 11% of the oldest cohort of Mexican Americans (aged 55-64) were found to have NIDDM compared to 4% of non-Hispanic whites of the same age. Analysis of the Hispanic HANES (HHANES) data based on laboratory and self reports indicated that in the oldest age group (65-74) diabetes was present in 17% of Anglos, 25% of Blacks, and 33% of Mexican Americans, Cuban Americans, and Puerto Ricans. Using only self-report data from the HHANES, diabetes prevalence of 17.5% of Mexican Americans 55-64 and 22.7% of those 65-74 was reported (Perez-Stable, et al., 1989). This is 2 1/2 times the 8.9% rate reported by a representative sample of all older Americans 65 and over in the Health Interview Survey (National Center for Health Statistics, 1990). No significant differences between older Mexican American males and females were found in the HHANES, although middle aged females 45-54 reported almost twice the prevalence that middle aged males reported (11% vs. 6%).

Over age 50, at least 10-15% of Hispanics will already carry a diagnosis of diabetes, but an additional 5-10% of the population remain undiagnosed. Older Hispanics with low socioeconomic status and/or low level of acculturation appear to be especially at risk (Hamman et al., 1989).

Comorbidity associated with diabetes mellitus plays a major role in the health status of older Hispanics. Mexican American diabetic subjects have more severe hyperglycemia and an increased prevalence of retinopathy relative to Anglo diabetics, and unfortunately, the diagnosis is frequently delayed in Hispanic elders (Appiah, Ganthier, & Watkins, 1991). There is a three-fold increase in the risk of clinical proteinuria in Mexican-American diabetics as compared to Anglo diabetics (Haffner, et al., 1989), and the incidence of end-stage renal disease due to diabetes in six times higher for Mexican Americans than for Anglos (Pugh, Stern, Haffner, Eifler & Zapata, 1988). The prevalence of diabetic neuropathy in Hispanic elders is about 32%, but this is not significantly different than that experienced by Anglo diabetics (Franklin, Kahn, Baxter, Marshall, & Hamman, 1990). History of diabetes is the most important risk factor for stroke in Hispanics (Sacco, Hauser, & Mohr, 1991).

Hispanic men and women with diabetes or impaired glucose tolerance are at greater risk for gallstone disease than those with normal glucose tolerance (Maurer et al., 1990), although advancing age and Mexican American ethnicity (as compared to other Hispanic or Anglo ethnicity) were associated with an increased risk for gallstone disease even in those with normal glucose tolerance. In summary, the earlier age of onset combined with its greater comorbidity, makes diabetes a major public health problem facing Hispanic elders and their health care providers.
Table 4

SUMMARY OF PROBABLE DIFFERENCES IN DIABETES-RELATED RISKS IN HISPANIC ELDERS COMPARED TO TOTAL OLDER U.S. POPULATION

<table>
<thead>
<tr>
<th>Type of Risk</th>
<th>Relative Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Insulin Dependent Diabetes Mellitus (NIDDM)</td>
<td>Increased</td>
</tr>
<tr>
<td>Obesity</td>
<td>Increased</td>
</tr>
<tr>
<td>Proteinuria</td>
<td>Increased</td>
</tr>
<tr>
<td>End-Stage Renal Disease</td>
<td>Increased</td>
</tr>
<tr>
<td>Retinopathy</td>
<td>Increased</td>
</tr>
<tr>
<td>Gallstone Disease</td>
<td>Increased</td>
</tr>
<tr>
<td>Neuropathy</td>
<td>No Difference</td>
</tr>
</tbody>
</table>

Hypertension and cardiovascular disease. While hypertension is now recognized as a risk factor for cardiovascular morbidity and mortality and possibly an etiologic factor in other illnesses in later life that result from vascular disease, it has not yet received the increased research attention it deserves among older Hispanics. The prevalence rate is higher than that reported in Anglos and Asians, but somewhat lower than that reported for Blacks (Caralis, 1990). Several investigations reported that a constellation of diseases (including obesity, non-insulin-dependent diabetes mellitus, and hypertension) is markedly increased in frequency among the Mexican population of South Texas (Hanis et al., 1983; Hanis, Ferrell, & Schull, 1985; Mueller et al., 1984; Stern et al., 1981a, 1981b; Stern, Rosenthal, Haffner, Hazuda, & Franco, 1984). These reports together confirm the notion that South Texas Mexicans have an increased risk for a combination of obesity, diabetes, and hypertension, and that increasing age has the most significant effect on blood pressure variability.

Analysis of data from HHANES suggests that greater age and increased acculturation are strong predictors of hypertension, implying that cultural determinants may be more important factors associated with the prevalence of hypertension in older Mexican Americans than is socioeconomic status (Espino & Maldonado, 1990). This finding is in interesting contrast to the decreased risk of diabetes found with increased acculturation, as noted above (Hazuda et al., 1988).
A study of the hypertension treatment beliefs held by older Hispanics conducted among a Washington, D.C. sample which included significant proportions of Cubans (36%), and high school (26%) and college (21%) graduates, found that while most were well-informed about such scientific treatments as weight-reduction and low-salt diets, respondents mentioned resting, drinking chamomile herb tea, and ice water as common treatments (Allinger, 1985). Since the vast majority (90%) of those interviewed believed in the efficacy of both the scientific and folk treatments, it is suggested that geriatric care providers consider using both in health education and treatment efforts to manage blood pressures within normal limits. Epidemiologic studies that find higher levels of undetected hypertension among Hispanics than among Anglos also find that Hispanics lag behind both Blacks and Anglos in treatment and control of high blood pressure. In those with mild-to-moderate hypertension, thiazide diuretics were found to be highly effective antihypertensive medication (Caralis, 1990). Angiotensin-converting enzyme inhibitors, such as captopril, have been shown to be effective in treatment of moderate-to-severe hypertension in Hispanic elders (Schoenberger, Testa, Ross, Brennan, & Bannon, 1990).

On the other hand, not all types of cardiovascular morbidity are necessarily increased by the greater prevalence of diabetes, obesity, hypertension, and smoking found in Hispanics when compared to Anglos. Findings from the San Luis Valley Diabetes study indicate that despite greater risk factors, Hispanics did not demonstrate more anginal symptoms than a comparable cohort of Anglos (Rewers, Shetterly, Baxter, Marshall, & Hamman, 1992).

Hypertension and diabetes put Hispanics at risk for stroke at younger ages than the overall aged population. A study of hospitalized stroke patients in Manhattan found that Hispanics (primarily from the Dominican Republic, Cuba, and Puerto Rico) had a greater proportion of intracerebral and subarachnoid hemorrhages than Anglos but the age-adjusted incidence of hospitalized stroke is no different for Hispanics than whites (Sacco et al., 1991). Espino and colleagues did find that the Mexican American residents of large nursing homes in San Antonio were four times as likely to have the diagnosis of stroke on admission as the Anglo residents (32% vs. 8%) (Espino, 1993; Espino & Burge, 1989).

Combining the evidence from both mortality and morbidity studies, Table 5 summarizes the current most likely conclusions in relation to the relative risks for various cardiovascular conditions comparing Hispanic elders with the total U.S older population.

Cancer. The information base concerning cancer among aging Hispanics is relatively sparse but gradually increasing. The results of earlier overall comparisons of cancer mortality were mixed, but the more recent findings of mortality and morbidity studies point to the patterns summarized in Table 6.
Table 5
SUMMARY OF PROBABLE DIFFERENCES IN CARDIOVASCULAR RISKS IN HISPANIC ELDERS COMPARED TO TOTAL OLDER U.S. POPULATION

<table>
<thead>
<tr>
<th>Type of Risk</th>
<th>Relative Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>No Difference</td>
</tr>
<tr>
<td>Myocardial Infarction</td>
<td>No Difference</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Increased</td>
</tr>
<tr>
<td>Stroke</td>
<td>No Difference</td>
</tr>
<tr>
<td>Lipid Disorders</td>
<td>Increased</td>
</tr>
</tbody>
</table>

Table 6
SUMMARY OF PROBABLE DIFFERENCES IN CANCER RISKS IN HISPANIC ELDERS COMPARED TO THE TOTAL OLDER U.S. POPULATION

<table>
<thead>
<tr>
<th>Type of Risk</th>
<th>Relative Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td>Decreased</td>
</tr>
<tr>
<td>Liver Cancer</td>
<td>Increased</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>No Difference</td>
</tr>
<tr>
<td>Pancreatic Cancer</td>
<td>Increased</td>
</tr>
<tr>
<td>Stomach Cancer</td>
<td>Increased</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>Increased</td>
</tr>
<tr>
<td>Prostatic Cancer</td>
<td>No Difference</td>
</tr>
</tbody>
</table>
A retrospective study of 408 patients with an average age of 54 years concluded that in Los Angeles County, immigrant Spanish surnamed females had a lower incidence of breast cancer, while indigenous (U.S. Born) Hispanic females had cancer rates similar to Anglos (Lee, 1985). This study also noted another significant finding: Hispanic patients with breast cancer are more likely to have significantly higher numbers of positive axillary lymph nodes. Additionally, Hispanic women are more likely to be in advanced stages of the disease at time of diagnosis and to live for a shorter time (Saunders, 1989). Early diagnosis of breast cancer may be missed due to the low rate of mammography screening in low-income women (Calle, Flanders, Thun, & Martin, 1993). Farrow and colleagues found that for women diagnosed at early stages of breast cancer, there was no difference by ethnicity in frequency of treatment of breast cancer by breast-conserving surgery, but Hispanic women were less likely to receive radiation therapy after the breast-conserving surgery (Farrow, Hunt, & Samet, 1992).

An increased rate of cervical cancer among Hispanic women seems to be due to an increased rate in the over-65 cohort, as younger Hispanic women have a lower rate relative to Anglos (Trapido, McCoy, Stein, Engel, McCoy, & Olejniczak, 1990). This skewed incidence may in large part be due to lower levels of Pap testing in older Hispanic women (Calle et al., 1993; Stern, Misczynski, Damus & Coulson, 1977). An analysis of Health Interview Survey data found that older Hispanic women were less likely than their Anglo and black counterparts to have had a Pap test; in fact less than half over the age of 60 had ever had one, and over one quarter (26.8%) over 70 had never even heard of Pap tests. Spanish-speaking women were five times as likely to say they had never heard of the test as English-speaking women, and Cubans were less likely to be have had the test than other Hispanic women (Harlan, Bernstein, & Kessler, 1991). Even in regions where the incidence of invasive cervical cancer is declining, the rate of occurrence in Hispanics remains twice that Anglos (Becker, Wheeler, Key, & Samet, 1992).

Hispanic men tend to have patterns of cancer incidence similar to those of non-Hispanic men: lung, prostate, colon and bladder are the most common sites. The relative incidence of cancer of the buccal cavity, liver, larynx and gallbladder were elevated in Hispanic males 45 years and older compared to non-Hispanics (Trapido, McCoy, Stein, Engel, Zavertnik, & Comerford, 1990).

These findings underscore the need of a health education and cancer detection program among the older Hispanic population. Yet another issue is the psychological adaptation to cancer. Ell and Nishimoto (1989) found that while the extent of disease at the time of cancer diagnosis did not vary by ethnicity or education, patients with less education reported greater role-functioning limitations, and that Hispanic patients with only an elementary education had poorer overall mental health status. Therefore, not only is there a greater need for health education in older Hispanic populations, but
specific information about cancer causes and treatment, and cancer support groups focused towards the needs of this population need to be developed.

**Acquired Immunodeficiency Syndrome (AIDS).** As of January, 1989, 15% of reported AIDS cases were among Hispanics, or nearly twice the Hispanic representation in the general population (Marin, 1989). However, Hispanics represent only 6.8% of reported AIDS cases in persons over 70. This is partly explained by the decrease with age in the proportions exposed by high risk sexual behavior and IV drug abuse. Older persons with AIDS are more likely to have undetermined means of HIV exposure and to die in the same month as the diagnosis is made. Disease progression and clinical deterioration appear to be more rapid in older people; however, to some extent this appearance of rapid progression may be due to delayed diagnosis because clinicians are less alert to the possibility of AIDS in older persons (Ship, Wolff, & Selik, 1991).

**Special populations at risk.** A group that deserves special consideration is older Hispanic farmworkers. In a statement on the status and needs of older Hispanic farmworkers prepared by the National Council of La Raza (Lopez, 1990), of the more than 3.5 million farmworkers in the US, at least one-third are Hispanic. Given their short lifespan, estimated in one survey to be just 49 years for migrants, older farmworkers cannot be defined as those 60 and over. Of the 338,000 Hispanic hired farmworkers reported by USDA, 18.8 percent are over the age of 45, and 7.7 percent are older than 55 years. The group tends to be undereducated, and more than half of Hispanic farmworkers age 55 and older speak English poorly or not at all. Farmworkers suffer the greatest number of heat-related illnesses and the highest rate of chemical injury of any occupational group, and have 3.5 times as many cases of urinary tract infection as the urban poor. In addition to dismal housing conditions and financial insecurity, lack of access to community-based services is a major problem for older Hispanics, especially for migrants (Lopez, 1990).

Hispanic populations that live adjacent to the US-Mexico border face unique challenges to their health. Drug-resistant tuberculosis remains a significant problem on the Mexican side of the border, and is a diagnosis that needs to be considered in older Hispanics with failing health. Environmental health suffers from the presence of polluting factories called *maquiladoras* in Mexico that release contaminants into surface water or underground aquifers, and which may be responsible for high blood levels of lead in persons living on both sides of the border (Warner, 1991).

**Health risk behaviors.** Data from HHANES have allowed examination of several health risk parameters that correlate with overall morbidity in populations in the US. In addition, these and other studies were examined to see if any correlations existed between the studied behaviors/diseases and level of acculturation as determined by the modified Cuellar Acculturation Scale (Cuellar, Harris, & Jasso, 1980). Of the
population sampled in HHANES, 18.9% of Mexican Americans, 34.7% of Cuban Americans, and 19.6% of Puerto Rican adults were ages 51-74 years.

Alcohol consumption appears to decrease with age in all groups, although Anglos report a significantly higher amount of drinking than Hispanic men or women (Molgaard, Nakamura, Stanford, Peddecord, & Morton, 1990). Older Hispanic women have especially low rates of alcohol use (Marks, Garcia, & Solis, 1990). Greater acculturation appears to be more predictive of the probability of being a drinker in women, and higher education among older women is positively associated with alcohol use (Markides, Ray, Stroup-Benham, & Trevino, 1990).

Smoking among Hispanics has become an increasingly visible problem, concurrent with increased marketing by cigarette manufacturers in this burgeoning group. There are differences in rates of smoking in the three main Hispanic groups, and variation based on age-grouped cohorts. Mexican American men had the highest rates of smoking of the three groups in the age range 55-74 years in an analysis of the HHANES 1982-1984 data, and markedly higher rates compared to Anglos and Blacks (Haynes, Harvey, Montes, Nickens, & Cohen, 1990). Mexican American men have a higher rate of smoking; however, they tend to be lighter smokers. Among women aged 55-74 years, the rates of smoking were markedly lower in all three Hispanic groups compared to younger age groups, and were about the same as smoking rates of Anglos and Blacks. There is a high age-adjusted prevalence of chronic bronchitis among Puerto Ricans, which may be due to the higher proportion of heavy cigarette smokers among Puerto Ricans and/or the high exposure to air pollution in New York City. Mexican Americans have a higher proportion of light smokers, and no association between smoking and chronic bronchitis (Bang, Gergen, & Carroll, 1990). HHANES data tend to suggest an inverse association between socioeconomic status and smoking prevalence for both men and women, and acculturation was positively associated with cigarette smoking only among Mexican American women (Haynes et al., 1990).

Obesity is a major health problem in Mexican Americans, and has been documented in the San Antonio Heart Studies with adults 25-65 (Hazuda et al., 1988; Hazuda, Mitchell, Haffner, & Stern, 1991). Depending on the strictness of the weight standard applied, 53% to 70% of the Mexican American men and 62% to 75% of the Mexican American women aged 55-65 were defined as overweight. Higher socioeconomic status and acculturation are associated with less favorable body fat distribution in men; in women, higher socioeconomic status and acculturation are associated with lower overall obesity and a more favorable body fat distribution (Hazuda et al., 1991).
MENTAL HEALTH

Life satisfaction and well-being. Compared to 62% of older Americans in general who see themselves as very satisfied with their life, less than half (48%) of the large sample of older Hispanics in the Commonwealth Fund study report that they are very satisfied. (Andrews et al., 1992). Those in better health and those with higher incomes were much more likely to report high life satisfaction, but education was not related. There was a tendency for those older Hispanics living alone to have somewhat higher rates of satisfaction (51%) than those living with their spouses (49%) or others (46%); among all older Americans those living with their spouses had higher satisfaction (65%). There was a dramatic difference in this study in the serious problems reported by Hispanic elders, compared to older Americans in general, which presumably help to account for the lower life satisfaction. Not enough money was reported by 41% of Hispanic and 14% of all elders; having too many medical bills by 32% of Hispanic and 17% of all elders; feeling lonely by 24% Hispanic and 7% of all; depending on others too much by 30% of Hispanic and 6% of all; and taking care of sick spouse or relative by 20% of Hispanic and 5% of all elders (Andrews et al., 1992).

Another analysis of the Commonwealth Fund study data found that some of the differences in life satisfaction could be explained by age at migration to the U.S. Those who immigrated in late adulthood had lower life satisfaction and more disability than those who had come in earlier ages or those who were born on the mainland U.S., but some of these differences seemed to be related to differences in extent of social contacts (Angel & Angel, 1992). A particularly striking finding in this analysis was the fact that Cuban American elders consistently reported higher life satisfaction, as well as better health, than older Mexican Americans or Puerto Rican elders on the mainland. The authors suggested that the differences might be due to the Cuban elders' benefit from residence in established ethnic enclaves (Angel & Angel, 1992).

Depression and psychological distress. A number of studies have documented a higher rate of depression and depressive affect among Hispanic elders, and several have attempted to identify the major correlates of negative mood. In a representative sample of Mexican Americans 45-and-over in San Diego, 16% scored in the depressed range of the Center for Epidemiologic Studies Depression (CES-D) scale; higher rates were found among women, those divorced or separated, those aged 75-and-over, and those with 12 or more years of education (Morton, Schoenrock, Stanford, Peddecord, & Molgaard, 1989).

The findings of an area-probability sampling of 700 older Hispanics living in Los Angeles County using a regrouped set of Comprehensive Assessment and Referral Evaluation (CARE) items to reflect Diagnostic and Statistical Manual III criteria found that more than 26% suffer from major depression or dysphoria, and that these affective disorders were strongly correlated with medical disability, including dementia (Kemp, Staples, & Lopez-Aqueres, 1987). Without physical health complications, the
rate was 5.5%, equivalent to other non-Hispanic populations. The biggest difference was in dysphoria, suggesting more of a demoralizing effect on the older Hispanic due to physical, and (probably) socioeconomic factors.

In the Los Angeles study the many correlates found associated with affective disturbance in older Hispanics included being female, inability to speak English, low income, being widowed (if male), having family members with serious health problems, and feeling lonely even when living with another person (Kemp et al, 1987). Similar findings resulted from an analysis of the responses of over 1300 Hispanic immigrants aged 65-and-over from the Commonwealth Study; results indicated financial strain exerted an especially deleterious effect on depressed affect, and suggested that acculturation had a beneficial effect, primarily because more acculturated Hispanic elders experienced fewer financial problems and less social isolation (Krause & Goldenhar, 1992). In a previous study, however, although older Mexican Americans with a preference for the Spanish language were found to have a lower sense of self worth and decreased feelings of personal control (which was associated with a greater increase in somatic symptoms), preference for Spanish was found to be related to less psychological distress (Krause, Bennett, & Tran, 1989).

Other research has also tried to uncover the relationship between acculturation and indicators of depression. In a study that assessed differences in depression between US-born and Mexico-born Mexican Americans, Golding and Burnam (1990) found that US-born respondents reported a significantly higher mean depression score using the CES-D than immigrants, and were more vulnerable to depression as a result of low acculturation or low educational attainment. In an earlier study Burnam and others found no relationship between acculturation level and lifetime prevalence of major depression, dysthymia, obsessive-compulsive disorder, or panic disorder but a higher prevalence of major depression and dysthymia among immigrants than US-born Mexican Americans (Burnam, Hough, Karno, Escobar, & Telles, 1987).

The report by Kemp et al. (1987) of their Los Angeles study notes that depressed respondents reported a greater reliance on others for daily tasks, and needing more help than they received. Fewer depressed respondents, particularly those who were females, reported they had someone to depend on in time of need or talk to when they had a problem. Similarly, fewer of the depressed Hispanics were members of clubs or other social organizations that held regular meetings. The study also found that depressed Hispanic patients took significantly more prescription drugs than did the non-depressed group, with differences apparently related to both the presence of medical illness and gender; depressed females received significantly more medication than non-depressed females, but there were no differences for males.

The study underscored the special concern regarding the apparent lack of either biological treatment or interpersonal treatment for depression among Hispanic elders. This research suggests that depression often presents itself differently among
elders, particularly those of Hispanic descent, and for that reason often goes unrecognized and, hence, untreated. In the San Diego study, a factor analysis of the CES-D responses provided evidence that older Mexican Americans, particularly immigrants, tended to somatize dysphoric complaints, or present with physical rather than emotional symptoms (Morton et al., 1989). Kemp and associates (1987) also suggested that physicians need to learn to thoroughly assess depression in all older persons, especially Hispanic patients. Despite the high incidence of depression in Hispanics, there has been an observed underutilization of counseling services by ethnic minorities as well as underrepresentation in the counseling profession (Thompson & Atkinson, 1991).

A series of large community surveys among Mexican Americans in San Antonio concerned their well-being and family relationships. The findings in relationship to depression and marital status are in agreement with previous community surveys showing females, particularly older ones, to be generally more depressed than males (Markides & Farrell, 1985). While married people generally had lower depression and other types of psychological distress than unmarried people, this does not hold true for older persons. The analysis comparing married and widowed older persons found that, consistent with recent literature, widowhood is not detrimental to the well-being of older people, as predicted by earlier gerontological theory.

Given the rarity of divorce and separation among this generation of older U.S. Mexicans, Markides and Farrell (1985) found it difficult to explain why divorced and separated older U.S. Mexicans were not more depressed than those who were married. It is, of course, possible that older U.S. Mexicans (whether widowed or divorced/separated) are able to reduce the risk of depression and psychological distress because of stronger extended family ties; however, based on their findings in relation to intergenerational solidarity and association, Markides and colleagues challenge the assumption that the extended family is automatically a source of warmth and support to the older U.S. Mexicans in contemporary urban society (Markides & Martin, 1990). In fact a startling finding was that high levels of association with children were significantly related to higher levels of depressive symptoms among elders (Markides & Krause, 1985).

Within the marital relationship, the three generation studies in San Antonio found that ratings of positive interaction between the spouses declined from middle to older ages among women, although it showed a slight increase among men (Markides & Hoppe, 1985). In trying to explain this phenomenon, the authors speculated that the role of the mother is extremely important in the Mexican American culture and that alternative roles might be scarce for older women, who also have a low propensity to terminate unsatisfactory marriages (Markides & Krause, 1986).
Dementia. Alzheimer's disease and other dementias place great demands on families, caregivers, and health professionals. The initial diagnosis is often difficult to make, especially in early stages of dementia. The Mini-Mental State Examination (MMSE) often is used by health professionals to screen for cognitive impairment. However, ethnicity and language may affect selected items on the MMSE, especially three of the orientation items, the attention/calculation items and the vocalization item (Escobar et al., 1986). Valle (1989) also suggests that there is no good Spanish equivalent for the language item "Repeat 'No Ifs Ands or Buts'." In addition, persons with fewer years of education score lower on the MMSE (Folstein, Anthony, Parhad, Duffy, & Gruenberg, 1985; Valle, 1989), as well as other neuropsychological tests (Lowenstein, Arguelles, Barker, & Duara, 1993) which may artificially lower the score of Hispanic elders.

Other tests are available that evaluate various components of mental status to differing degrees (Baker, 1989), but selection of any given test must take into account cultural and educational differences or risk overdiagnosis of cognitive impairment in Hispanics. Valle (1989) stresses the importance of using "culture-free/culture-fair" instruments. Through the Alzheimer's Research Center at the University of Southern California, Taussig and her colleagues have translated and validated a battery of neuropsychological tests to measure cognitive performance among Spanish-speaking elders (Taussig, Henderson, & Mack, 1992). Lowenstein and colleagues (1993) have also validated a similar Spanish language battery of dementia assessment instruments with a population of predominantly Cuban American elders in Miami.

Use of interpreters. The difficulty of providing effective and culturally appropriate geriatric health care for Spanish-speaking elders is significantly increased when the providers do not speak Spanish and there are no trained interpreters available. This situation is even more critical in the case of mental health services when use of family members is by definition very problematic. Even when other interpreters are available, common mistakes such as omission, addition, condensation, substitution, and role exchange can substantially alter the information so critical for accurate diagnosis and management of emotional or organic conditions (Vasquez & Javier, 1991).

CAREGIVING

Studies of Latino family caregivers of elders with dementia on both the East and West Coast have found some unique cultural themes. Henderson and Gutierrez-Mayka (1992) interviewed 37 caregivers in Tampa from Cuban, Spanish, and Puerto Rican backgrounds and found very clear patterns of gender role responsibility for caregiving which require females to be the primary burden bearers, extending to daughters-in-law and sometimes to female non-kin. A stigma of "craziness" related to dementia was frequently reported that may extend to the entire family, especially if there is deviant behavior exhibited by the elder. The authors also emphasize the generational or
cohort differences, resulting in lower likelihood that older caregivers would attend support groups or utilize services. Strong confirmation for the expectation that Latino families expect women to assume the caregiving roles was found in a qualitative study using in-depth interviews of 30 caregivers in San Jose, California, most of whom were Mexican American (Orona & Alkayyali, 1992). In these families, knowledge of the etiology and symptomatology of Alzheimer’s disease was often limited, especially for those caregivers whose primary language was Spanish. Most did not receive adequate explanations from their physicians, even though the diagnosis was given. Contrary to the expectations of the stereotypical Latino family, support for the primary caregivers from extended family members was very minimal. Only in one of the 17 families was caregiving responsibility actively shared among the available family members; in a few others caregiving daughters were given assistance by their own daughters.

Interviews were also conducted by Cox and Monk (1993) with a predominantly Puerto Rican sample of 86 Hispanic family caregivers of dementia patients in New York and Baltimore. Their respondents were found to have a mean score on their depression measure indicating depressive symptoms (18.5 on the CES-D). The depressive symptoms were positively related to adherence to norms of filial support obligating children to care for their parents and not to use professional help. The majority (57%) had no one in their support network who could provide total or respite support care for the impaired elder.

Reports of two programs providing interventions for caregivers from Hispanic families provide models adapted to the cultural issues. Henderson and colleagues in Tampa have developed and piloted an approach to working with community agencies to initiate culturally appropriate support groups, and a manual is available from Suncoast Gerontology Center in the University of Southern Florida (Henderson, 1990, 1992). A successful psychoeducational intervention using a cognitive therapy approach to help family caregivers cope more effectively and reduce stress from anger has been translated into Spanish, adapted to be more culturally appropriate, and validated with 60 Hispanic caregivers in the San Francisco Bay Area by Gallagher-Thompson and her colleagues. Compared to non-participating caregivers, those who took the eight-session course were found to: 1) suppress their anger less, that is acknowledge their feelings of frustration more and deny them less; and 2) have a larger support network on whom they could call for help. The manuals for participants and leaders are available in both Spanish and English from the Stanford Geriatric Education Center (Gallagher-Thompson et al., 1992).
PART IV

HEALTH CARE UTILIZATION

The relatively poor health status of Hispanic elders has been described in this paper. While data on their utilization of health care services, particularly preventive and short-term care services, has been ambiguous and controversial, it is clear that Hispanics are seriously underrepresented as providers of services in the health occupations. In 1989 Hispanics accounted for 2.2% to 3% of the total dentists, registered nurses, pharmacists, and therapists in the United States. The proportion of physicians is somewhat higher, about 5.4%, but still does not approach the proportion of the total U.S. population that is Hispanic (almost 10%). This deficiency of Hispanic health professionals may well threaten the level of access of Hispanics, particularly non-English-speaking Hispanics, to the health care system (Ginzberg, 1991).

There has been a widespread assumption that Hispanics underutilize the formal health care system because of a lack of educational or financial resources, or of cultural factors (Andersen, Lewis, Giachello, Aday, & Chin, 1981; Clark, 1959; Cuellar & Weeks, 1980; Edgerton & Kario, 1969; Giachello, 1985; Hoppe & Heller, 1975; McLemore, 1963; Nall & Speilberg, 1967; Sena-Rivera, 1979; Suchman, 1964; Weaver, 1973; Welch, Comer, & Steinman, 1973). However, more recent studies indicate that the issue of service utilization is highly complex. The fact that many studies combine age, cultural, and/or geographic groups of Hispanics has also tended to cloud the issues (Espino, 1988; Lopez-Aqueres, Kemp, Staples, & Brummel-Smith, 1984). Some recent studies have been limited to smaller and more well-defined groups, perhaps at the expense of generalizability. In this discussion, the issue of health care utilization will be discussed in four sections—physician and short-term care services, mental health services, long-term care services, and folk healers, which involve separate issues for Hispanic elders.

PHYSICIAN AND SHORT TERM CARE SERVICES

Studies which combine all age groups of Hispanics often show that Hispanics underutilize physician services. Trevino and Moss (1984) found in a national probability sample that Mexican Americans had the lowest rate of physician visits for any group studied (3.7 visits per person per year compared to 4.7 visits for the total population). Roberts and Lee (1980) found that Chicanos in Alameda County, California, reported lower use of medical care than did Anglos and Blacks, especially for general medical examinations. Wells and colleagues used 1982 and 1983 population survey data from Los Angeles and determined that Mexican Americans, especially those who are less acculturated, use fewer outpatient services than do
Anglos and are less likely to get care for health promotion or minor physical problems (Wells, Hough, Golding, Burnam, & Karno, 1987).

In contrast, a 1982 Harris survey found that Hispanics do not differ significantly from Anglos in use of hospitals, physicians, or outpatient departments and emergency rooms. Preventive use of health care was also found to be high, although satisfaction with health services was low (Andersen, Giachello, & Aday, 1986).

In an analysis of the (HHANES) data of 1982-1984, Solis and colleagues found that for the Hispanic population in general, access was strongly related to utilization of preventive care services. Most important were having a routine place for care and having health insurance. For Mexican Americans, language but not ethnic identification was also an important predictor of utilization (Solis, Marks, Garcia, & Shelton, 1990). Using the same survey data, Estrada and colleagues found that the cost of health care was the most frequently encountered barrier to health care among Mexican Americans. These data were not analyzed separately for elders. (Estrada, Trevino, & Ray, 1990)

Studies which focus on utilization behavior of only older Hispanics, however, have somewhat different results. When Trevino and Moss (1984) analyzed physician visits separately for persons 65 and over in their national probability sample, they found that while physician utilization for the entire group of Hispanics in the sample was low compared to the rest of the population, use by Hispanic elders was relatively high. Male Mexican American elders had 9.8 visits per person per year, compared to 5.8 for older males of all ethnic groups combined, 5.7 visits for Anglo male elders, and 6.3 visits for black male elders. All Hispanic male elders combined had 8.9 visits per year, and Cuban American male elders had 11.3 visits per year. In Hispanic groups in this study, unlike non-Hispanic groups, males had higher rates of physician visits than did females, although female Hispanic elders had higher physician visit rates than did black or older Anglo females.

Hendershot (1988), using 1985 and 1986 National Health Interview Survey data, found that Mexicans and Mexican Americans over 65 are more likely than the total population to see themselves as being in poor health and are also more likely to consult a physician. Foreign-born persons of Mexican origin were more likely than U.S.-born persons to have had six physician contacts or more, indicating that increased acculturation may not increase utilization.

The study by the Commonwealth Fund found that older Puerto Ricans report the worst health status (63% in fair or poor health) followed by Mexican American elders (54%) and Cuban Americans (46%). Puerto Rican elders were also found to be

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2Puerto Rican male elders had 6.9 visits per person per year. However, the small sample size for this group makes comparisons inappropriate.
the most likely to use medical services, averaging 11 annual physician visits. Thirty-two percent had been hospitalized within the last year (Commonwealth Fund Commission, 1990).

Villa and Crimmins (1986) found in a representative sample of Los Angeles elders that Hispanic elders have more doctor visits and use Medicaid for reimbursement more often than Anglos. Health status was the most significant predictor of doctor visits, followed by ethnicity. On the average, Hispanic elders were found to have four more annual doctor visits than older Anglos. Other things being equal, Hispanic elders were 25% more likely than Anglos to use Medicaid. Ethnicity was not related to length of hospital stays.

In a three-generations study of Mexican Americans in San Antonio, Markides, Levin, and Ray (1985) found that elders do not underutilize physicians. The "older generation" in their study had an average of 6.2 physician visits per year. The people with the most symptoms made the most visits, and acculturation did not affect utilization. The authors suggest that low physician utilization of the overall Mexican American population can be explained by lack of health insurance. They state that where insurance coverage is high, such as in the case of Mexican Americans using Medicare, the utilization of physicians will be similar to that of Anglos.

This theory is borne out by Lopez-Aqueres and colleagues (1984) who found in a study of Los Angeles Mexican-American elders that 79.4% had seen a physician at least once in the past year. Most had seen a general practitioner. Those who had not seen a physician were more likely to be young-old (60-69) or lacking health insurance. Income and health insurance were also related to source of care (private physician versus clinic). Older Mexican Americans in the study were found to make less use of specialists and more use of general practitioners.

Cox (1986) compared samples of Hispanic, Portuguese, and Vietnamese elders (persons over 60) living in Santa Clara County, California. She found that the number of physician visits per year was approximately the same for all three groups and for the general population 65 and over (4.3 visits). Needs factors were the most important determinants of physician utilization, with diabetes being a significant predictor for Hispanics. In this study income, insurance, education, language, and distance from the physician had no direct effects on utilization.

Escovar and Kurtines (1983) attempted to explain factors affecting service utilization by a sample of 88 Cuban American elders. (Services included but were not limited to health care.) They found that the users of formal delivery systems tended to be recent arrivals in the U.S. who retained a strong Hispanic cultural identity and who perceived themselves to be in poor health. They also found that the Cuban elders made "selective and differential use of informal networks, with their children being the primary source of informal support" (Escovar & Kurtines, 1983).
Much less information is available on short-stay hospital visits by Hispanic American elders, however, Trevino and Moss (1984) did analyze this variable. They found that 18.7% of Hispanic elders in their national sample reported at least one hospital episode within a year of the interview, compared to 18.1% of the total population of elders. By subgroup of elders, 18.5% of Mexican Americans, 10.5% of Puerto Ricans, and 20.3% of Cuban Americans reported a hospital stay within the past year. While the total population of persons 65 years and older who used the hospital reported an average of 14.5 days in the hospital, Hispanic elders reported an average of 13.2 days (14.6 for Mexican American elders, 12.2 for Puerto Rican elders, and 10.6 for Cuban American elders). Thus, although Hispanic elders are slightly more likely to be hospitalized, their stays are shorter. While 43.8% of all elders in the sample had stays of fewer than eight days, 49.3% of Hispanic elders had stays in this range. On the other hand, while 29.5% of all elders had stays of 15 or more days, only 26.4% of Hispanic elders had stays of that length.

Currently available data, then, suggest that Hispanic elders do not underutilize physician and short term hospitalization services. A number of unanswered questions remain, however. For one, utilization studies do not estimate optimal utilization based on an objective standard of health. Thus, although Hispanic elders in these studies have more physician visits than the total population, it is possible that their health conditions should theoretically result in an even higher number of visits. A further problem is with sampling. It seems possible that a segment of the Hispanic population, particularly undocumented individuals, are being omitted from these surveys. The rate of inclusion of very impoverished, rural, undocumented, and/or migrant Hispanic elders in surveys such as the National Health Survey should be investigated further.

MENTAL HEALTH SERVICES

Although the need to provide appropriate mental health services for Hispanic elders has been identified since the 1970s (Miranda & Ruiz, 1981), few data exist on utilization of mental health services by Hispanic American elders. Starrett, Rogers, and Decker (1992), using a national probability sample collected in 1980, found that Hispanic elders rely on themselves to solve their mental health problems more often than they use the church, physicians, or professionals. Need was the strongest indicator of use, and use of the church was preferred over use of physicians or other professionals. Vernon and Roberts (1982) found similar rates of use of mental health specialists for Anglos and Mexican Americans of all ages with psychiatric disorders. Griffith (1985) on the other hand, controlled for psychological distress and found that Mexican Americans in Southern California had much lower utilization than Anglos, although the two groups did not differ in anxiety, psychosocial dysfunction, or depressive symptoms. However, for persons over age 45, Mexican Americans had more problems with psychosocial dysfunction than Anglos. The author points out that
the study did not assess the contribution of "naturally-occurring social support networks" toward the remediation of psychological impairment, and suggests that the Mexican American community may provide such networks to a greater degree than the non-Hispanic community.

Wells and colleagues suggest that mental health services may be especially underutilized by less acculturated Mexican Americans (Wells et al., 1987). Using data from the Los Angeles site of the NIMH Epidemiologic Catchment Area Program, the authors found Anglos with psychiatric disorders at least twice as likely as Mexican Americans with psychiatric disorders to visit the mental health clinic. Utilization was lowest by the least acculturated Mexican Americans. However, no separate analysis was done for elders.

A study of a catchment area in Pasadena, California, states that all elders underutilize mental health services there, with utilization by Hispanic elders being the lowest (Schweon, Alumbaugh, Hernandez, & Bowman, 1986). Fourteen percent of the population in their catchment area are elders, but they represent only 6% of clinic clients. They describe a successful program of mobile outreach to Hispanic elders. Interestingly, initial referrals were from family members seeking help for Hispanic elders, rather than from the elders themselves.

Valle has been a strong proponent of using the members of natural networks in the Mexican American community to provide preventive mental health services to elders and other family members at risk (Valle, 1980; Valle & Martinez, 1981). He has developed a conceptual framework as well as community organization strategies for programs to use indigenous service brokers (or natural helpers) to link mental health services with individuals in need. A similar strategy to use natural support systems for Puerto Rican elders has been advocated by Delgado (1982).

Although the data currently available suggest that Hispanic elders underutilize mental health services, several factors remain unclear, such as the underlying cause, the extent of underuse, and whether the pattern of underutilization is more severe than for elders of other ethnic groups.

LONG TERM CARE SERVICES

In this discussion, long term care services are defined as including both extended care in institutions such as nursing homes or residential care homes and also care delivered to elders in their own homes, such as housekeeping or nutrition services and home care by health care professionals. Hispanic elders show a greater need for long term care services than does the population at large. (See section on functional status in Part III.) What evidence there is, however, suggests that Hispanic elders are underutilizing long term care services.
Greene and Monahan (1984) analyzed formal and informal long term care utilization by a random sample of Hispanic and Anglo elders already enrolled in the Community Services System in Tucson, Arizona. The older Hispanic enrollees in the sample exhibited greater impairment in activities of daily living (ADLs) although they were on the average 6 years younger than their Anglo counterparts. The sample of Hispanic enrollees received more formal services in the areas of transfer and finances but much less formal assistance in the areas of housework/chore services and laundry. This is notable because the Community Services System devotes nearly 80% of its direct services expenditures for such services, indicating that Hispanic elders consume a disproportionately small share of these services, even in the presence of higher levels of impairment. Further data analysis indicated that at least part of the disproportionate low utilization of the formal services by Hispanic enrollees arises from their use of informal support, which was higher than among the Anglo elders. In a sample of 6,326 disabled elders who had applied for home care, Kemper (1992) also found that Hispanic elders received less formal care and more resident and visiting informal care than did Anglo elders. (Resident informal care was defined as care delivered by unpaid persons living with the elder.) Other authors have also concluded that Hispanic elders’ reliance on family members to provide personal care results in lower utilization of formal long term care services (Greene & Monahan, 1984.)

Starrett and Decker (1984) tested a causal model of the utilization of social services by Hispanic elders. They found the most important predictors of use to be knowledge of social services, followed by need, income, health status, and ethnicity, with knowledge of social services having the strongest direct effect. The authors conclude that service utilization is far more complex than previous studies have indicated, but that information about social services is a very important component. At the White House Mini-Conference on Hispanic Aging in 1981, older Hispanics testified that the language barrier is the major reason why they do not know about or use social services (Lacayo, 1982).

High rates of poverty among older Hispanics means dependence on Medicaid to cover long-term care costs not covered by Medicare. Forty-four percent of poor older Hispanics are covered by Medicaid, compared to 29% of all older poor persons. However, one-third of Medicaid application sites in the seven states with the largest Hispanic populations indicated that they provided no special services to help staff work with monolingual Spanish-speaking clients. Forty-nine percent of offices cited inadequate information as the reasons for low levels of Medicaid enrollment in Hispanic populations (Lopez & Aguilera, 1991).

In-home services. Use of in-home care services appears to vary by ethnic subgroup. Using data from the 1988 national survey of Hispanics age 65 and older sponsored by the Commonwealth Fund Commission on Elder People Living Alone, Wallace and Lew-Ting (1992) found that Puerto Ricans are twice as likely as other Hispanic groups to use in-home health services, and Mexican Americans are less likely than other
subgroups to use these services. They found that acculturation, measured by knowledge of English and age at immigration, had little or no effect on the use of in-home health services, but that factors such as health insurance and the local availability of services have a moderate effect on all Hispanic subgroups. The authors of the study believed that older Puerto Ricans, who typically live in New York City, used more services because they had access to a well-developed network of services, whereas Mexican Americans were more likely to live in less urban areas and in states where fewer services were available and where Medicaid eligibility criteria were stringent (see Part II for information on geographic distribution).

Nursing home care. The 1985 National Nursing Home Survey found that only 2.7% of older persons cared for in nursing homes were Hispanic. About 3% of Hispanics 65 and over are in nursing homes, compared to 5% of Anglo elders; of those 85 and over, 10% of Hispanics and 23% Anglos live in nursing homes (Agree, 1987). In a 1990 study, the National Coalition of Hispanic Health and Human Services Organizations reported that in the seven states with the largest Hispanic populations, per capita spending for skilled nursing and intermediate care facilities was 15 times greater for Anglo Medicaid recipients than for Hispanic recipients (Lopez & Aguilera, 1991). Eribes and Bradley-Rawls (1978) also found that Hispanics are underrepresented in the nursing home population relative to their proportion of the at-risk population. In a study in Phoenix, Arizona, they found that while 5.3% of the total population of elders reside in nursing homes, only 2.3% of the Mexican American elders lived in those facilities.

Contrary to their expectations, Eribes and Bradley-Rawls (1978) found a strong positive relationship between the incidence of poverty among Mexican American elders in a particular geographic area and their utilization of nursing homes; the relationship between the incidence of Mexican American elders living alone and residence in a nursing home in a specific area was also found to be positive. Yeo (1993) found that when Hispanic elders were living in multigenerational households and contributing to household income, family members were reported to be less inclined to have them move into residential long-term settings.

Espino and colleagues have reported studies in different geographic areas that indicate that Hispanic residents of nursing homes are younger and more impaired than non-Hispanic white residents in the same facilities. In a retrospective study in a New York City nursing home, they found that Puerto Ricans were, on the average, 7.6 years younger than Anglos upon admission and had less total ADL functional capacity, including less mobility and greater mental impairment (Espino, Neufeld, Mulvihill, & Libow, 1988). In a similar study in San Antonio, Mexican American nursing home residents were found to be almost 10 years younger, and much less likely to be married or living with someone else on admission than their Anglo counterparts. Mexican American residents were significantly more impaired on all ADLs except bathing and also on memory and mood status; they were 3 1/2 times more likely to
carry the diagnosis of stroke and almost eight times more likely to carry the diagnosis of diabetes than Anglo residents (Espino, 1993; Espino & Burge, 1989). They hypothesize that nursing home placement is the choice of last resort for Hispanic elders and their families. As a consequence, reliance on family support is longer and use of formal long term care services begins at higher levels of disability (Espino et al., 1988).

A study by Friends and Relatives of Institutionalized Aged, Inc. (1984) in New York City found that private nursing homes with better reputations tended not to accept Hispanic or black elders, who were therefore usually referred to less reputable nursing homes having empty beds to fill. Lack of access to good nursing home care presumably results in families making greater efforts to care for elders at home.

In summary, underutilization of long term care services by Hispanic elders is well-documented but the reasons for this underutilization are less well understood. The fact that Hispanic elders already enrolled in a case management program continued to underutilize personal care services indicates that knowledge of service availability and need for the services are not the only determining factors in utilization. Cultural factors and reliance on informal sources of support appear to continue to be factors in underutilization, despite the finding of some authors that the traditional Hispanic extended family is undergoing rapid change (Cantor, 1979; Lacayo, 1993; Markides, 1983; Maldonado, 1977; Newton, 1980), and the concern of others that Hispanic elders do not benefit from the perpetuation of the myth that the family can meet all their needs (Cuadrado, 1988; Rathbone-McCuan & Hashimi, 1982). From the studies of ethnically-oriented nursing homes by Yeo (1993) no models of nursing homes designed especially to meet the needs of Hispanic elders were found in the Western states, although a there is a long-standing successful model in Chicago. It may be that models of care for combining the unique needs and cultural preferences of Hispanic families with the formal services available have yet to be developed in most communities with large numbers of Hispanic elders to help family members with the burden of care (Torres-Gil & Fielder, 1987).

NATURAL OR FOLK HEALING

Taken as a whole, Hispanic folk healing systems include various complex and sophisticated systems that utilize a variety of healers and techniques. Among Mexicans, the system is known as *curanderismo*, among Cubans as *santeria*, and Puerto Ricans as *espiritismo*. Across the systems there is a variety of health care generalists and specialists, including *curanderos* (general practitioners of Mexican folk healing), *yerbistas* (herbalists), *santeros* (Cuban faith healers), and *espiritistas* (Puerto Rican faith healers).
While some earlier studies of curanderismo found it to be alive and active (e.g., Alegria, Guerra, Martinez, & Meyer, 1977) many recent studies question its salience. Data from the Southwest sample of the Hispanic Health and Nutrition Examination Survey (HHANES) reveal that only 4.2% of the sample reported consulting a curandero in the 12 months preceding the survey (Higginbotham, Trevino, & Ray, 1990). Andersen et al. (1981) found that 21% of Hispanics in the southwestern states use herbs and home remedies to treat illnesses, compared to 12% of the overall U.S. population. However, this study did not find any use of curanderos. Similarly, Cox (1986) found some use of special teas or herbs in the Hispanic population in Santa Clara Valley, California, but did not find use of curanderos. Salcido (1979) using an unrepresentative sample of Mexican American elders, found that the majority indicated the use of folk remedies, but 95% denied using folk healers. Casas and Keefe (1987) reported that folk medicine had little significance to Mexican Americans in Southern California. Estrada (1986) found the use of folk practitioners in El Paso, Texas, to be negligible. Vega (1980) found that in a random sample of 585 Mexican Americans in Santa Clara County, California, those who were interviewed in Spanish reported that 4.5% had seen any type of natural healer in the last 12 months, while those interviewed in English reported 2.2% had done so.

On the other hand, Scheper-Hughes and Stewart (1983) found in Taos, New Mexico at least some elements of curanderismo are supported by the population, although it has moved from being a primary and important source of medical care to an alternative and very occasional source.

Available data certainly indicate the utilization of folk healers by Hispanic elders is not so predominant that it can be considered an explanation for the underutilization of other health services.

PART V

CULTURAL TRADITIONS, BELIEFS, VALUES, AND ETHICAL ISSUES

The experiences and expressions, symbols and materials, customs and behaviors, morals and values, beliefs and attitudes created and communicated among individuals and between generations over time and space are thought of as cultural traditions. In each group and subgroup there are characteristic ways that individuals learn languages, definitions of illness, healing practices, hygiene habits, nutrition perspectives, ways of perceiving the world and identifying themselves in relationship to others in that world, and interactive ways of defining the meanings of such cultural intangibles as respect and trust, power and prestige. Thus, the importance of cultural patterns cannot be underestimated, particularly in health care contexts. Geriatric care
providers should note that interpersonal misunderstandings often can be traced to cultural miscommunications.

When the U.S. Hispanic cultural tradition is considered, providers need to be sensitive to variations that exist according to the national and regional origins of the various ethnic and racial groups that are classified under the broad category of "Hispanic." As already evident, Cubans have cultural experiences and expressions that in some ways are similar to those of Puerto Ricans, Dominicans, and other Caribbean Americans whose cultural tradition is more rooted in an amalgamation of Afro-Hispanic mulato traditions, and who are currently found primarily on the Atlantic coast of the U.S. These traditions are significantly different from those of Mexicans, and Central and South Americans, whose cultural tradition stems more from the mestizo Indo-Hispanic traditions, and who are presently found primarily in the Southwest and on the Pacific Coast of the U.S.

Nevertheless, there are a number of unifying cultural themes or patterns that underlie the beliefs and values related to health care shared by most U.S. Mexicans and some other Hispanics, and which (besides Spanish language use) distinguish them from the dominant Anglo cultural tradition. The most important of these are familismo, jerarquismo, personalismo, espiritismo, and presentismo.

**FAMILISMO**

Most Mexicans, Cubans, Puerto Ricans, and other Hispanics place a great deal of value on their family relations. Attempts to instill a sense of family pride and obligation begin early and are nurtured throughout a person's life. Most Hispanics are socialized to believe that the needs or welfare of the family or individual family members, particularly the very young or very old, should take precedence over one's own needs. Children, adults, and elders alike are often reminded that, during good times or bad, *la familia* comes first.

It is also within the family context that U.S. Hispanics are taught the value of cooperation versus competition, mutual assistance versus individual problem-solving, and sharing as opposed to withholding resources. Thus, Hispanic families usually function through social reciprocity, accessing shared resources when necessary. The division of labor and resources usually depends on the family members' needs, according to age and gender. Even in situations where extended family members are living in separate households, grandparents, uncles and aunts, siblings, cousins, in-laws, and even godparents often provide nurture, guidance, support, and control functions (Ho, 1987).

Mexicans, Puerto Ricans, Cubans, and other Hispanics in the U.S. appear to have experienced significant changes in both the structure and function of families and
households in recent decades. As a result, several different types have been observed: the nuclear household with wife and husband only, or parents and children; the multi-generational extended family household including grandparents and other real or fictive relatives in addition to parents and children; the single-parent-headed nuclear family household, with or without the head's significant other; and the so-called "sub-extended" family, which is a nuclear family household dependent on an extended network of kin for moral, social, and fiscal assistance. (See Part II for a data on living arrangements.)

Among Hispanics, families remain the most important system of support for their older members. However, even the earliest studies of familial support for older Hispanics found that they received less aid from their families than they expected from church and government support systems (Crouch, 1972; Mizio, 1974). One study of older Mexicans in San Antonio, Texas, found that they may be more disadvantaged relative to Anglos than suggested by stereotypic perspectives. While having good relations with their adult children, older San Antonio Mexicans had high expectations of their children that often went unfulfilled due to urbanization and greater acculturation of the young (Markides & Martin, 1983). Similarly, research findings suggest that extended family relations are stronger among rural Hispanics in New Mexico and Texas, which implies that urbanization negatively affects the close knit links between older persons and their families (Korte, 1978; Laurel, 1976).

Implications for the geriatric provider include the need to expect that in most cases family members will be closely involved in the health care and health decisions affecting older patients, but to recognize that those family members may be experiencing considerable stress. (See Part III for information on family caregiving.)

**JERARQUISMO**

*Jerarquismo* has to do with the way individuals deal with each other in terms of the relative positions they occupy within vertical or hierarchical social structures (Szapocznik, Scopetta, & de los Angeles Aranalde, 1978). This pattern contrasts with that of "egalitarianism" where the style and substance of personal relations are determined by the sense of equality that stems from the individuals occupying similar level positions in horizontal networks; or with "individualism," where persons relate to each other as autonomous individuals, independent of vertical or horizontal structural contexts.

Theoretically, traditional Hispanic families, regardless of structure, are considered patriarchal with the eldest male considered the head, and everyone else expected to respect his authority and obey his decisions. But in practice, there is much variation, with evidence of increasing numbers of matriarchal or female-dominated households among all groups (Baca Zinn, 1979, 1982; Grebler, Moore, &
Jerarquismo thus conforms to relative age, gender, race, and class positions, and basically responds to the lineal structures of the family on the one hand, and of society on the other. The family hierarchy emphasizes gerontocracy, or the authority of older persons over younger, with most respect and control over resources given to the oldest members, and least to the youngest. Similarly, this pattern assigns greater value to machismo with an emphasis on the authority, respect, and control over resources of males over the females in the family.

PERSONALISMO

Hispanics value interpersonal relations and social interactions in which individuals deal with each other as caring, complete persons rather than impersonal players of segmented roles. The emphasis is on those inner qualities that constitute the uniqueness and fundamental self-worth of each person, regardless of social, economic, or political status. Rather than trusting or respecting a person primarily on the basis of past achievements or future possibilities, as in the Anglo tradition, Hispanic personalismo emphasizes the building of confianza/trust, respeto/respect, orgullo/pride, and dignidad/dignity, which are very important in the delivery of health care (Newton, 1980; Solis et al., 1985) through formal but friendly interaction over a period of time. According to some authors, Puerto Ricans have particularly articulated the need to be treated with respect and dignity (Henderson & Primeaux, 1981; Lauria, 1972; Scott, 1974). Physician-patient interactions characterized as neutral by Anglo patients may be perceived as negative by Hispanic patients (Perez-Stable, 1987). Techniques that have been used to facilitate a more personal relationship with older Hispanic patients include inquiring about the well-being of the patient’s family, and the providers’ sharing something about themselves or their own family.

ESPIRITISMO

Espiritismo is the belief system that the world is inhabited by both good and evil spiritual beings who can affect humans, particularly their health and well-being, in both positive and negative ways. This belief system is an integral component of Hispanic cultural tradition which finds expression in both folk medicine and religion-based healing. Hispanic curanderismo, santeria, and espiritismo reflect a value orientation based on the perceived working relationship of humans to their natural and supernatural environments, one that involves neither complete subjugation to, nor complete domination of, their physical and spiritual worlds. Thus, this orientation can be of great therapeutic significance in geriatric health care, since aging individuals who share it may be convinced that certain practices can help prevent, cause, or cure...
illnesses. Geriatric health providers should note that: 1) treatment of older Hispanics should involve consideration of elders as whole individuals with both bodies and spirits in need of healing; and 2) the two are frequently seen to be integrally intertwined by the elders themselves.

PRESENTISMO

Presentismo refers to the emphasis or value given to present time and problems, as opposed to "traditionalism" which emphasizes past times and problems, or "futurism," which places an emphasis on times and problems yet to come. For more than 30 years, beginning with the work of Kluckhohn and Strodtbeck (1961), a number of studies have contrasted Anglo future time orientation with Hispanic present time orientation. Most have concluded that this orientation implies such potentially problematic behaviors as immediate rather than delayed gratification, and a focus on short-term rather than long-term planning (Casavantes, 1970; Papajohn & Spiegel, 1971; Ramirez & Castaneda, 1974). But this present time orientation can serve as a functional quality leading to a focus on the immediate crises at hand, rather than what happened in the past, or may happen in the future. The possible effects of this orientation suggest that its adherents may delay seeking health care treatment until late in the stage of disease and may also be less inclined to practice health promotion/disease prevention behaviors.

ETHICAL ISSUES

Given the value systems of the Hispanic population in the United States, the context of what is "ethical" means more than just the sum of the moral principles and practices necessary to provide proper geriatric health care to aging Hispanics. It also means the set of principles or moral values shared by various Hispanic individuals or groups which guide their actions and behaviors with regard to aging processes or the older segment of the population; it includes concepts of what they approve of as "good," "desirable," or "right," and disapprove of as "bad," "undesirable," or "wrong." This makes the task of cross-culturally defining ethical issues and drawing out their implications somewhat more difficult, because such basic philosophical problems as whether there are right or wrong, good or bad, desirable or undesirable ways of growing old for Hispanics, and ways of treating older Hispanics in geriatric health care settings must be considered. At the same time, basic ethnological questions must be considered, such as: whether certain values are inherent in the nature of the grand Hispanic cultural tradition inherited from the Spanish colonizers; whether these are shared by contemporary Mexicans, Central Americans, Puerto Ricans, Cubans, and other Caribbean and South Americans living in the U.S.; or whether they are merely relative cultural conventions that vary from time to time, place to place, group to group, and person to person.
Ethical difficulties seem almost inherent when there are differences in the cultural definition of a situation, or between the perceived values and rights of health care providers and the needs of patients and their significant others. Questions have even been raised as to the cultural appropriateness of some of the cornerstones of ethical decision making used regularly in health care, such as the principle of individual autonomy, which may be less relevant for Hispanic and other groups with strong traditions of familism. The following summary of a case helps illustrate how some of these salient ethical issues emerge from the conflict of cultural values and clash of perspectives between health care providers and patients (Kim, 1983).

A 70-year-old U.S. Mexican, Spanish-speaking woman was admitted to an acute care hospital due to coma of unknown cause. She had been found unresponsive in the vineyards, in 104 degree midday heat, where she had been picking grapes alongside family members earlier that day. The initial working diagnoses on admission were massive left hemispheric stroke and aspiration pneumonitis. On the second day after admission, an endotracheal tube was inserted and the patient was placed on mechanical ventilation after sudden respiratory arrest, and full supportive measures were given, including fluid and electrolyte replacement, antibiotics and insulin. Two electroencephalograms taken on consecutive days recorded the absence of brain wave function. The criteria for brain death were satisfied on the eighth day.

The medical team therefore announced to the family that the patient’s brain was dead and that all supportive measures were to be stopped. The family, tired from the eight-day hospital vigil, was unprepared to receive this declaration. What seemed like chaos to the hospital staff ensued—men, women and children, wept and unequivocally insisted in both Spanish and English, "Do not stop resuscitative measures."

The medical staff initially interpreted this response as an "appropriate expression of hysteria, grief and denial of death." Several hours later, the family’s disbelief continued at the bedside: "Que es ‘brain death?’" To them, the patient was asleep, her body still warm, heart still beating, lungs still breathing and legs and arms still twitching every so often. How could she possibly be dead?

The delay caused by these Mexicans’ simplistic questions annoyed the medical staff, especially because they had repeatedly
been given full explanations. The house staff was further outraged that here was an older Mexican patient certainly not benefiting from continued care, yet her "selfish" and "ignorant" family members were diverting precious medical resources. Eventually the medical staff refused to justify the prolonged occupation of a bed by a dead patient to the Hospital Review Committee. Thus, on the tenth day they pronounced the patient dead and removed the equipment. The only further communication from the medical staff to the family was to inform them that the body had been transferred to the morgue where it could later be claimed.

Since there are no set rules covering cross-cultural ethical situations like this, the primary concerns should be (a) cross-cultural sensitivity to the very existence of an ethical situation and (b) development of decision making and communicating skills in the ethical context (French, 1979). This case points to the following implication: The pitiful communication breakdown might possibly have been averted had someone perceived the cultural value orientations affecting the perception of major ethical issues evident in this situation.

Based on the personalismo value orientation, health care providers were expected to be warm, personal and concerned in all aspects of the patient's life, rather than cold, impersonal, and concerned with only her medical condition. Given the familismo value orientation, this family took a much more active role in the medical care of their older family member than expected by the health providers. This Mexican family felt the responsibility for making the care decisions for their comatose elder, whereas the hospital staff, given their professionalism value, assumed that their special training gave them the authority to decide.

Anglo ethnocentrism is a form of ethnic discrimination that promotes negative attitudes toward those who are not English-speaking whites, and places lesser value on Spanish-speaking non-whites in society. Contrary to the evidence, this set of biased values assumes that Hispanic cultures are characterized by ignorant and simplistic views of health care. As a consequence, health providers may develop an impaired relationship with Hispanic patients and their families who, in turn, may be less inclined to trust the providers and cooperate with or accept their decisions. This impaired relationship may also make the providers inclined to avoid communicating with Hispanic patients and their families as much as possible. Ethnocentrism among health providers may engender discrimination against Hispanic elders, and decrease the likelihood that they will receive the services they need.

In the above case, had the medical team been more respectful, empathic, and less ethnocentric, had it sought to establish a personalized relationship with the family, and had it used bilingual interpreters to insure optimal communication and cooperation
with the family during the ten-day hospital course, mutual trust and goodwill might very well have been established. With such a bond between care providers and family members, together they might have jointly decided to terminate supportive care with dignidad.

An especially problematic ethical decision for many Hispanic families is the request by a physician for an autopsy after the death of a loved one. A study in a large county hospital in Bexar County, Texas, found that rates for autopsies permitted by Mexican families for members aged 61-80 were 18% compared to 25% for similar Anglo families (Perkins, 1991). In interviews with Mexican and other informants the author found that the following culturally based values may create conflicts for Mexican American families faced with an autopsy request: the professional orientation of the physician may neglect to attend to the grieving family’s needs for personal expressions of sympathy and for time to make decisions; if the family believes more in fatalistic forces than in the power of medical science over disease, few benefits to autopsies are perceived; Roman Catholic families may place considerable importance on maintaining the body "unmutilated" based on the belief that God wants the human body returned to Him whole after death, or that "mutilation" is a desecration of the temple of the Holy Spirit; and families may believe that the soul may maintain the ability to feel pain until some time after death.

Suggestions for the physician to help alleviate possible cultural conflicts in autopsy requests with Mexican families include: not mentioning autopsy before the death of the patient to avoid the appearance of giving up on the patient too soon; keeping the patient and a trusted family member or friend (especially the family’s primary decision maker) informed about the diagnosis, treatment, and prognosis in clear and understandable terms throughout the illness; being sure that the physician who has the best rapport with the family, usually the family physician, makes the request for autopsy; maintaining respect for family members’ beliefs and traditions, such as asking if they would like to use an interpreter, asking if they prefer to include a priest or chaplain or other trusted advisors in the discussion, shaking hands and touching the family members, acknowledging their loss, and speaking to them at eye level (Perkins, 1991).

PART VI

CONCLUSIONS AND IMPLICATIONS FOR GERIATRIC HEALTH CARE PROVIDERS

One important conclusion that emerges from this review is that older Hispanics are quite diverse. A dominant theme of this paper is that heterogeneity and ethnic-
specific identity are significant factors in any examination and explanation of health problems and needs among older Hispanics, and therefore, should be important considerations for geriatric health care providers. The older Hispanic population is one of the fastest growing segments in the nation. Since all indicators suggest that this group will continue to grow at a phenomenal rate, geriatric care providers must plan accordingly.

Older Hispanic women suffer multiple disadvantages; depression, diabetes, and cervical cancer number among the serious health problems they face. Geriatric health providers must develop programs to address their needs. However, when any Hispanic elder presents for medical care, screening should be focused on those treatable diseases most commonly left undiagnosed, such as those in Table 7.

Table 7

<table>
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<tr>
<th>Target Disorder</th>
<th>Diagnostic Measure</th>
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<tr>
<td>Diabetes</td>
<td>Blood glucose: if fasting &gt;140 mg/dl, or random &gt;200 mg/dl, confirm with repeat measure of fasting blood glucose to establish diagnosis</td>
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<tr>
<td>Hypercholesterolemia</td>
<td>Random cholesterol: Obtain fasting lipid panel if screening cholesterol is abnormal</td>
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<tr>
<td>Diastolic Hypertension</td>
<td>Sitting and standing blood pressure, Repeat on 3 separate occasions over 2 months if it is abnormal</td>
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<tr>
<td>Cervical Cancer</td>
<td>PAP smear</td>
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Future cohorts of aging Hispanics will include increasing proportions of native-born citizens and long term U.S. residents. New groups of Hispanic elders will grow in importance, such as those from Central and South America. Hispanic ethnic groups will exhibit a variety of traits and each, therefore, must be treated differently. The importance of cultural patterns cannot be underestimated, particularly in a health context. Geriatric health providers should be aware that interpersonal misunderstandings can often be traced to cultural misunderstandings. Listed below are some of the more obvious cultural implications for providers.
A. Many providers carry out their treatment plans based on a model of independent aging individuals who function alone and decide for themselves what is best. This may not hold true for Hispanic elders. Providers should be ready to consider the entire family, not just the aging individual, in the decision-making process. Hispanic cultures and kinship patterns can make it more likely that family members provide strong support for needy elders, but geriatric professionals need to understand that there is no such entity as "the Hispanic family." Flexible definitions of the family are called for, including the possibility that some elders have little or no extended family support.

B. Migration, acculturation of children and grandchildren, inability to find employment, poor health, and later life transitions may undermine the older person’s position of authority within the family. The traditional jerarquismo or hierarchical age/gender/birth order relationships between the older Hispanic and adult children and grandchildren may have been disrupted by any number of factors. Therefore, one of the first tasks of geriatric care providers may be to help families restructure their relationships, by operating from a position of authority, so that older persons are in a position of respect to respond to appropriate health care treatment.

C. Because of the need to meet Hispanic elders’ expectation and value of personalismo and also to provide the respect for jerarquismo, geriatric health care providers should be less direct, less confrontational, less businesslike, and more personal in their relationship with older Hispanics and their family members, especially the males. Language is most important during the initial phase of treating elders and family members who are unable to speak English fluently. Providers who cannot speak Spanish should exercise care in selecting translators to avoid adverse effects. The more polite and respectful usted (you) should be used in addressing elders, rather than the more informal tu. It is important for many Hispanic elders to establish a personal trusting relationship with their providers before they comply with any health care recommendations.

D. Health care plans for older Hispanics frequently should be oriented toward "present time." Older patients often seek treatment as a result of some specific emergency and expect providers to resolve the immediate problems before dealing with long term plans. Hispanic elders and their families may be reluctant to invest time and energy in a process that does not address the immediate health concerns. Therefore, geriatric providers should learn to develop plans for management of ongoing
chronic conditions coordinated with care for the emergencies when elders present themselves for treatment.

E. Providers should have some acquaintance with the events that have helped to shape their older Hispanic patients’ lives. In order to take an adequate social history, especially as it relates to mental health, some knowledge of the important historical influences on the cohort of older individuals from Mexico, Cuba, or Puerto Rico is essential (Yeo & Hikoyeda, 1992).

This review clearly reveals significant gaps that remain in the theoretical and practical methods of dealing with the problems of aging Hispanics. There is an obvious need to develop an overall conceptual model and technical approach that integrates the ethnogeriatric perspective in all aspects of care. The underutilization of available health care resources by Hispanic elders and their families emphasizes the need to develop culturally competent models of care, and this is particularly important in the area of long term care services. The future promises an increasing knowledge base on which to build these models as the currently funded research on the health of older Hispanics yield their results (Williams, 1991). The challenge is to find creative ways to increase the application of present and future knowledge of the needs of older Hispanics, as well to integrate more Hispanic providers, into the American health care system. Torres-Gil and others paint a future of increasing diversity in our aging population, which provides us with both opportunities and challenges, resulting in either age-race stratification or alliances between different age and ethnic cohorts to meet the health and educational needs of both Hispanic and non-Hispanic groups (Stanford & Torres-Gil, 1991; Torres-Gil, 1992). As we move toward this increasing diversity, it is essential that we recognize the importance that ethnicity plays in “determining the essence of lifestyles of older people as anchors in society” (Stanford & Torres-Gil, 1991).
REFERENCES


# CURRENT AND FUTURE ETHNOGERIATRIC MATERIALS

## A. SGEC WORKING PAPER SERIES AND OTHER PRINTED RESOURCES

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<td>a. Aging and Health: American Indian/Alaska Native Elders</td>
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<td>3. Proceedings of SGEC Conferences</td>
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4. Controlling Your Frustration: A Class for Caregivers

5. Ethnogeriatric Curriculum for Different Disciplines: (1996 New Releases)
   Medicine, Nursing, Nutrition, Psychology, Rehabilitation, Social Work and General Health Professions (See Ethnogeriatric Curriculum List) $7-16.00

B. EDUCATIONAL VIDEOTAPE


2. "The Need for a Culturally Competent Model of Long Term Care," Lecture by Gwen Yeo, PhD, in AARP Series on Ethnicity and Long Term Care, 1997 $20.00

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<td>B. NURSING</td>
<td>1. “Ethnogeriatric Nursing in the Context of Rehabilitative Care: Caring for the Emerging Minority,” Irene Daniels Lewis, RN, DNSc, FAAN and Melen McBride, RN, PhD, 1996.</td>
<td>$7.00</td>
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<td></td>
<td>2. “Introduction to Ethnogeriatric Nursing Care Principles, A Curriculum Module for Nurse Assistant, Vocational Nurse, and Associate Degree Nursing Programs,” Ruth Madalena, MA, 1996</td>
<td>$7.00</td>
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<td>3. “Ethnogeriatric Module for Family Nurse Practitioner and Physician Assistant Programs,” MaryEm Wallace, PhD, RN, FNP and Melen McBride, RN, PhD, 1996.</td>
<td>$10.00</td>
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<td>&quot;Ethnogeriatric Social Work: An Ecological Model for Practice,&quot; Juliette S. Silva, PhD, 1996.</td>
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<td>F. GENERAL HEALTH PROFESSIONS</td>
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<td>&quot;Eldercare in a Multicultural Society, a Model Course for Health Professions Students,&quot; Debra David, PhD, 1996.</td>
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**ADDITIONAL GERIATRIC RESOURCES**

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| H. Demographics & Health Risks of Ethnic Minority Elders: A Curriculum Module Resource Packet, Gwen Yeo, PhD, 1996. | $10.00   |
|                                                                                                                   |          |
| J. Core Curriculum in Ethnogeriatrics, Second Edition. Developed by the members of the Collaborative on Ethnogeriatric Education. October 2000. | $20.00   |
| K. Ethnic Specific Modules for the Ethnogeriatric Core Curriculum Second Edition.                             | $35.00   |

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