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Equitable Health Systems: Cultural and Structural Issues for Latino Elders

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I. INTRODUCTION

This Article examines the extent to which the U.S. healthcare system is equitable for older Latinos, using the World Health Organization (WHO) and the related Organization for Economic Cooperation and Development (OECD) criteria on health outcomes, access/responsiveness and financing. We argue that improving health equity requires more than actions aimed at health behavior and culturally-based beliefs targeted at the individual. Improving equity also requires changes in broader social and political processes affecting entire populations and organizations of care, paying special attention to how these changes affect the Latino elderly.

Healthcare is particularly important for the older population. Persons age 65 and older have the highest overall rates of death, disease and disability, as well as the most frequent and intense use of medical services.[1] U.S. public policy has acknowledged the high medical care needs of many elderly by establishing Medicare as a universal health insurance starting at age 65, and supplementing it with Medicaid, the public-assistance program for low-income older persons.[2] Over the next five decades, members of the population age 65 and older are expected to double from nearly thirty-five million individuals to over eighty million, representing more than one-fifth of the total U.S. population.[3] In recent years, much has been written about the aging of the U.S. population and its implications for the financing of federal and state programs including Social Security, Medicare and Medicaid.[4]

The WHO has developed a set of criteria for evaluating the performance of health systems in their efforts to improve health. These criteria focus on three important areas of performance: health outcomes, the "responsiveness" of healthcare systems and the financing of those systems.[5] Moving beyond the fiscal policy emphasis promoted by international lending institutions and many U.S. economists,[6] the WHO argues that each area should be assessed on the equity of results in addition to a system's efficiency.[7] This emphasis on equity draws attention to the distribution of results in each area, requiring us to identify population characteristics that are markers of inequality and stratification in society. The OECD recently expanded this framework to incorporate more attention to the equity of access to healthcare.[8]

In the United States, race and ethnicity have historically served as principal fault lines in the distribution of social benefits and economic outcomes, notwithstanding the Fourteenth Amendment.[9] Regardless, the substantial public resources and policy effort focusing on elderly health tends to assume a relatively homogeneous elderly population.[10] Such assumptions are unwise given the increasing racial and ethnic diversity found among the elderly population.

By 2050, an estimated 35% of this population will also be members of an ethnic minority population, double the number reported in 2000.[11] Indeed, the Census Bureau projects that while the non-Latino white population age 65 and older will increase by 81% the Latino population age 65 and older is expected to increase 592% between 2000 and 2050.[12] While the Latino population is traditionally a younger population because of relatively high fertility rates, declines in mortality and reduced fertility, as well as the aging of immigrants have led to the "graying" of the Latino population.[13]

The diversity of the elderly population is not only important from a demographic perspective, but also because the experience of aging varies greatly across groups, revealing significant inequities in health and socioeconomic status. For example, while poverty rates over the past few decades improved among the elderly population, minority elderly persons remain overrepresented among the ranks of the poor.[14] Similarly, while the health of the older adult population has improved,[15] Latinos and other minority groups have disproportionately high prevalence rates for chronic and disabling conditions.[16] Additionally, access to the healthcare services to prevent and treat these conditions continues to vary by race and ethnicity.[17] The Department of Health and Human Services (HHS) recognizes these inequities and has set a national goal to eliminate health disparities among segments of the population, including differences that occur by gender, race, ethnicity, education and income.[18] Eliminating inequities in healthcare requires examination of the health of the population and the determinants of health at both the individual and broader sociopolitical level.

II. THE DEMOGRAPHY OF THE LATINO POPULATION

The Latino population is the fastest growing population in the United States, currently representing almost 12% of the total U.S. population.[19] The Latino population will surpass the African American population by 2005 to become the second largest racial/ethnic group in the United States, increasing to ninety-eight million individuals by 2050 and representing approximately one-quarter of the U.S. population.[20]

Yet, as the Latino population increases in number, it also ages. Currently, there are 1.9 million elderly Latinos representing 5.6% of the elderly population; by 2050 the Latino population age 65 and older will comprise 16.4% of the U.S. elderly population.[21] It is important to note that the Latino population includes different ethnic groups that share a common language but represent separate and distinct cultures. Mexican Americans account for 66% of the total Latino population living in the U.S., followed by South/Central Americans at 14%, Puerto Ricans at 9%, Other Latinos at 6% and Cubans at 4%.[22] The breakdown is somewhat different among the elderly Latino population. While Mexican Americans remain the clear majority, Cubans and Puerto Ricans have a higher representation. Among Latinos age 65 and older, Mexican Americans represent 53% of the population, followed by Cubans at 16%, South/Central Americans at 13% and Puerto Ricans at 10%.[23] Much of what we know about the health, social and economic status of the Latino population is based on the experience of Mexican Americans and, to a much lesser degree, the experience of the other Latino ethnic groups.

III. HEALTHCARE OUTCOMES: INEQUITIES IN ELDERLY LATINOS' HEALTH STATUS

The primary objective of health systems is to improve the health of populations.[24] While wealth and the social and physical environment are important determinants of inequitable health outcomes,[25] healthcare systems also play an important role.[26] Examining the equity of health status is therefore a key indicator of equity in healthcare systems. Equity in health outcomes can be determined by making a number of comparisons between Latino and non-

Latino while elderly in terms of mortality rates, morbidity rates, functional status and self-assessed health.

A. Mortality

Studies focusing on mortality find that Latino older persons have lower mortality rates than non-Latino whites for certain disease conditions. Cross-sectional data from the National Center for Health Statistics[27] show that Latinos age 65 and older are less likely than older non-Latino whites to die from heart disease, cancer or stroke. The National Longitudinal Mortality study offers further evidence of the Latino mortality advantage: both genders and all Latino subgroups have lower death rates among middle-aged (45–64) and elderly Latinos as compared to non-Latino whites.[28]

Among the Latino subgroups, Cubans have the most pronounced advantage and Puerto Ricans the least.[29] Puerto Ricans have higher all-cause, age-adjusted mortality rates than Cubans (406.1 versus 299.5 per 100,000) or Mexican Americans (348.4 per 100,000).[30] This pattern among Latino ethnic groups seems logical since the socioeconomic status of the Cuban population is higher than that of Puerto Ricans and Mexican Americans. The Latino advantage for mortality relative to non-Latino whites is surprising, however, given the disproportionately high poverty levels, low education and greater risk profile for disease found among the Latino population. Some have referred to this pattern of high risk and low mortality as an epidermiological paradox.[31]

The mortality advantage enjoyed by Latinos for cancer and heart disease, however, does not extend to all other disease conditions. Latinos of both genders, for example, have a higher mortality at all ages from diabetes.[32] The mortality rate for diabetes among middle-aged and older Latinos is twice that of the general population.[33] In addition, Latinos have higher mortality from chronic liver disease, homicide and HIV as compared to the general population.[34]

The Latino mortality pattern results in Latinos having a higher life expectancy relative to other racial and ethnic groups. In 2000, the average life expectancy at birth for the total U.S. population was 73.9 years for males and 79.4 years for females, whereas the life expectancy for Latino males and females was 75.2 and 82.8, respectively.[35] Latino life expectancy at age 65 (males 19.1 additional years, and females 22.4 additional years) exhibits an advantage as well when compared to the total population (males 15.9 additional years, and females 19.5 additional years).[36] Yet while Latinos live longer than other populations, evidence suggests that they do so in relatively poor health.

B. Morbidity

Some of the advantages that Latinos experience in the areas of mortality and life expectancy do not extend to morbidity. Data on the incidence and prevalence of disease among the population find that Latinos have higher rates of a number of diseases that significantly impair individuals' functioning and quality of life. It is estimated that nearly 85% of elderly Latinos have at least one chronic condition.[37] Latino elderly experience major medical problems including high prevalence rates for arthritis, cognitive impairment, diabetes, cardiovascular disease, depression, hypertension and cerebrovascular problems.[38] Mexican Americans are more likely than non-Latino whites to report having high blood pressure,[39] and Latinos overall have a higher prevalence of influenza, pneumonia, gallbladder disease, and infectious and parasitic diseases.[40] Studies focusing on cancer indicate that Latinos are more likely to have cancer of the cervix, stomach, liver, esophagus, pancreas and gallbladder.[41] Additionally, elderly Latinos are at a greater risk for developing liver cancer, pancreatic cancer, stomach

cancer and cervical cancer, as well as hypertension and lipid disorders.[42] They also have higher rates of undiagnosed hypertension compared to non-Latino whites.[43]

One of the most significant and consistent findings is the excessive prevalence of diabetes found in the Latino population, particularly among Mexican Americans.[44] This is particularly significant since diabetes is considered an "ambulatory sensitive condition," meaning that adequate outpatient medical care can reduce the severity of the condition and lower hospitalization and complication rates.[45] Rates of non-insulin dependent diabetes are two to five times greater for Latinos than among the general U.S. population in both sexes and at every age.[46] Latinos also have a higher mortality from diabetes than blacks or non-Latino whites, regardless of gender or age.[47] They also have earlier onset and more severe forms of the disease. Among elderly Latinos, Type II diabetes is associated with muscle loss and functional impairment.[48] These Latinos also experience higher rates of diabetes-related complications, which include conditions such as kidney failure, loss of limbs and blindness.[49] Secondary conditions associated with diabetes can often be prevented or delayed with adequate medical care,[50] indicating that the higher complication rates for Latinos may be an indicator of inequitable medical care.

C. Functional Status and Self-Rated Health

Many of the disease conditions noted above have consequences for physical and social functioning.[51] As Table 1 *infra* demonstrates, older Latinos are more likely than non-Latino whites to report needing assistance in Activities of Daily Living (ADLs) that involve personal care functions as well as Instrumental Activities of Daily Living (IADLs) that involve household care functions. Within each ethnic group, the disability rates rise as income declines. Older Latinos who live in poverty are more likely to have ADL needs but are less likely to have IADL needs as compared to similar non-Latino whites (Table 1).

Latino elderly, on average, experience earlier and more functional declines than the rest of the older population.[52] Mexican American elderly are more likely than non-Latino whites to report difficulty eating, toileting, dressing, preparing meals, shopping, using the telephone and doing light housework.[53] Disability is not necessarily a static phenomenon, however, and some functionally disabled persons regain their independence, such as after post-stroke rehabilitation. Latinos age 60 and older not only have a greater prevalence of ADL and IADL difficulty, but also are less likely to recover from these difficulties when compared to non-Latino whites.[54] For Latinos, living longer, therefore, may not necessarily mean more years with a desirable quality of life.[55] One study estimated that the total life expectancy of Latinos at age 15 is two years longer than that of non-Latino whites (64 versus 62 additional years), but the disability-free life expectancy is two years shorter (49 additional years for Latinos versus 51 for whites).[56] Accordingly, researchers argue that among Latinos, physiological aging tends to precede chronological aging so that Latinos in their late forties have health profiles similar to non-Latino whites who are age 65.[57]

A global indicator of health status is how individuals self-assess their own health, Health status research commonly asks individuals it; overall, they would say their health is excellent, very good, good, fair or poor, This question correlates highly with later mortality rates as well as current morbidity rates and is considered a good global health measure.[58] As seen in Table 1, about 20% more older Latinos than older non-Latino whites rate their health fair or poor, a gap that remains when only considering those living in poverty.

In summary, despite longer Latino life expectancies, significant inequities exist for older Latinos in a number of health outcomes including some chronic diseases, disability and self assessed health. The additional years of life, therefore, do not result in adding "more life" to their years.[59]

IV. HEALTHCARE PROCESS: INEQUITIES IN ACCESS AND RESPONSIVENESS

Health outcomes are not the only measure of equity in healthcare systems. The process by which the system provides those services is also important, independent of the health outcomes. The WHO's framework for assessing healthcare systems therefore includes "responsiveness" as the second indicator of health systems.[60] The dignity, autonomy and confidentiality that health systems afford those who use them are indicators of the process or way in which services are delivered. The OECD adds an explicit measure of access as a criterion in the process of care in the WHO framework.[61] By dividing access into availability, accessibility and acceptability of care, an evaluative framework for the process of care criteria integrates the OECD structural issues with the WHO interpersonal issues.[62]

"Availability" commonly refers to the physical presence of medical services for potential users, as well as the operating hours and services offered at the facility.[63] The creation of community health centers and the designation of medically underserved areas in the 1960s were both attempts to correct geographic disparities in the availability of medical services for low income and minority populations.[64] Elderly persons who live in designated health professional shortage areas (HPSAs) are likely to have impaired availability because of the undersupply of providers and, as a consequence, receive less necessary care than those living outside of shortage areas.[65] Elderly Latinos continue to experience difficulty in obtaining care because it is not available nearby. Among older Latinos in urban areas who are in Medicare fee-for-service, 17% have to travel over thirty minutes to reach their primary care provider, compared to fewer than 7% for non-Latino whites.[66] Although travel time is not statistically different for Latinos and non-Latino whites in Medicare Health Maintenance Organizations (HMOs) in urban areas, older Latinos in both HMOs and fee-for-service categories were less satisfied than older whites with die ease of getting to their doctor. In rural communities, persons living in predominately Latino areas have fewer doctors per person and are further from hospital services than similar communities that are predominately non-Latino white.[67] Older Latinos also have much lower satisfaction levels than non-Latino whites with the night and evening hours of their providers in both fee-for-service and managed care settings.[68] These data suggest that the level of services available to older Latinos is less than that available to older non-Latino whites, which increases the difficulty of obtaining needed medical services and thereby creates inequities in the process of care.

"Accessibility" refers to the means that people have to obtain medical services.[69] The most commonly cited accessibility barrier is financing, and extensive research documents the barriers to medical care for non-elderly persons who do not have health insurance.[70] Even though almost all older persons are covered by Medicare and therefore are "insured," Medicare's uncovered services, copayments, deductibles and premiums actually mean that almost half of all beneficiaries' total medical care costs are not covered by the program.[71] Average out-of-pocket healthcare, not including nursing home or home healthcare costs, exceeded $2,430 spending per older person in 1999.[72] Financial barriers are particularly strong for elders with chronic health conditions and without employer-subsidized supplemental coverage or Medicaid.[73] Latino elders are more likely than non-Latino whites to report delaying medical care because of the cost of care when they are in Medicare fee-for-service, which requires much higher copayments and deductibles than HMOs.[74]

National data on medical care spending by older Latinos is sparse, but available data show barriers to healthcare for low-income elders. Low-income elders are significantly more likely to report delaying or not receiving necessary medical and dental care. In 1993, about one-quarter of all older persons reporting family incomes below $ 10,000 also reported that they had unmet medical or dental needs. This compares with 13% of those with family incomes of

$10,000 to $ 19,999, and 6% of those with family incomes of $20,000 to $34,999 who reported not receiving needed care.[75]

Other accessibility barriers can include transportation difficulties, long waiting times to get appointments, bureaucratic barriers for securing needed referrals to specialists and complicated paperwork for obtaining services or reimbursement from supplemental insurance policies.[76] Transportation barriers are more common among Latino than non-Latino while elders.[77] perhaps because the lower economic profile of Latino elders reduces automobile ownership and availability. Less research has been done on the impact of other organizational barriers to accessibility for Latino elders, but lower levels of education, English ability and income would suggest that they would be particularly susceptible to bureaucratic or reimbursement barriers to care.[78]

"Acceptability" of care refers to the extent to which services meet users' value orientations.[79] This domain of access is most commonly measured through surveys of user satisfaction and is important because potential users may not make use of available and accessible healthcare services if those services do not appear appropriate or meaningful to them.[80] Acceptability is also the subdomain of our schema that most closely maps the WHO's definition of responsiveness.

Acceptability also appears to have attracted the most policy activity in recent years. The concern with acceptability for Latinos falls primarily into the area called "cultural competence." The U.S. Department of Health and Human Service's Office of Minority Health published an extensive set of guidelines on cultural competence,[81] and the language-related components are now codified by the U.S. Office of Civil Rights as a "[p]olicy guidance on the prohibition against national origin discrimination as it affects persons with limited English abilities."[82] This statement notes that persons with "limited English proficiency" (LEP) may not receive information they can understand about public services they are eligible for, and when they try to use those services, they may encounter communications difficulties that reduce the efficacy of the service. "Services denied, delayed, or provided under adverse circumstances have serious and sometimes life threatening consequences for an LEP person and generally will constitute discrimination on the basis of national origin, in violation of Title VI."[83] The issue of language is particularly important for Latino elderly, 86% of whom speak a language other than English at home, and 38% of whom do not speak English well or at all.[84]

A number of structural or organizational issues that go beyond language and culture affect the acceptability of care for older Latinos. These include the institutional organization of care, continuity of care, and societal discrimination and policies that shape older Latinos' comfort and trust in the medical care system. The institutional context within which care is provided has an effect on the level of satisfaction of older Latinos. Older Latinos in Medicare HMOs report lower levels of satisfaction with their care than non-Latino whites, while both groups have similar levels of satisfaction when they are in the Medicare fee-for-service program.[85] Many of the satisfaction indicators were lower for older Latinos in HMOs than those in fee-for-service. The perception that their doctors were not rushed, far example, was 26% in fee-for-service, but only 12% in HMOs. The higher dissatisfaction in HMOs for Latino elders remained even after controlling for education, health status, income and other variables commonly associated with satisfaction with care.[86] The responsiveness of a healthcare system to the expectations of older Latinos may be based on the way that the delivery of care is organized and the incentives that the organization provides, which may be independent of the cultural competency of the staff.

The organization of our medical care system also shapes the extent to which there is continuity of care between patients and providers. Continuity of care in HMOs is hindered In those plans

with high rates of new patients leaving within a few months after signing up, as well as when doctors drop plans.[87] In addition, those in fee-for-service whose usual source of care is not a doctor's office, such as those who normally use clinics or hospital outpatient departments, are more likely to see different doctors at each visit; only 62% of older Latinos report a doctor's office as their usual source of care compared with 83% of non-Latino whites.[88]

Continuity of care is important in building a relationship between provider and patient that promotes trust and a better therapeutic retationship,[89] especially for Latinos and African Americans.[90] Among urban older Latinos, about one-third of those in fee-for-service have seen the same physician for under three years, and about three-fifths of those in HMOs have seen the same physician for under three years, rates that are about 10% higher than for comparable non-Latino whites.[91] To the extent that this disadvantage in continuity of care is the result of high turnovers of patients and doctors in HMOs that attract Latinos and higher rates of clinic use in fee-for-service, this inequitable continuity of care is the outcome of the organization of medical care in the United States.

In addition, some of the "unacceptable" elements of medical care are likely caused by perceptions of broader social discrimination that makes minorities distrustful of established social institutions, A national survey of adult Latinos of all ages found that 82% felt that discrimination against Latinos in American society was a current problem, and40% reported that they or someone close to them had been discriminated against because of their ethnicity in the previous five years.[92] In the area of healthcare, families with immigrant members have faced concerns about using public programs because of worries that the use will make it difficult for them or their family members to gain permanent residence or even citizenship. Being a "public charge" has been a worry even for those not legally subject to the provisions under immigration law because of past unevenness in its enforcement and publicity about its applicability.[93] Thus, making older Latino healthcare recipients comfortable with using appropriate health services may also require systemic changes in society that eliminate the fear of using public services as well as broader ethnic discrimination. These issues could be considered structural barriers to acceptability since they transcend conventional considerations of cultural competence.

Finally, provider stereotypes of patients affect how doctors interact and treat patients.[94] A variety of studies have shown that doctors are less participatory in their decision making with patients of color than with whites, and it is likely that these practice styles are influenced by stereotypes of the patients.[95] Ironically, programs designed to promote cultural competency could promote stereotypical thinking by practitioners, so care must be taken to assure that practitioners are taught to understand each patient's attitudes and behaviors rather than fixed generalizations about entire groups.[96]

When promoting equitable healthcare for racial and ethnic groups focuses on language or other cultural barriers, it is critical to remember that these deterrents to adequate healthcare assume the availability and accessibility of those services. Issues of cultural competence have been long ignored and deserve policy attention, but we risk diverting attention and resources from availability and accessibility if making services culturally competent is the only effort towards achieving equity of health services.

V. HEALTHCARE FINANCING

The third key area identified by the WHO and OECD as an equity issue is medical care financing. Fairness in financing occurs to the extent that individuals pay for medical care based on their ability to pay rather than their medical needs. Large and unexpected medical care costs affect a small proportion of the population, but most disease is not easily predictable at the individual level. Health insurance that involves financial risk sharing and prepayment

addresses the problem of devastating medical costs. Also, out-of-pocket costs are often regressively financed, with the degree of regression based on the amount a person pays for medical care (including insurance premiums) as a percent of their discretionary income.[97]

Latino elderly are more likely to have no insurance than non-Latino white elderly (about 5% versus 1%),[98] which might place this small group at risk for potentially catastrophic medical care expenses. If these uninsured elders are permanent U.S. residents, however, they are eligible in most states for Medicaid if they have almost no assets and very low incomes or have medical expenses that leave their remaining income low enough.[99]

Being underinsured is a more significant problem then being uninsured for the elderly. As noted in the discussion of accessibility, Medicare has a number of uncovered services in addition to copayments and deductibles. These costs lead many elders to obtain supplemental coverage that pays for costs such as deductibles and, sometimes, prescriptions; private policies are generically called “Medigap” insurance.[100] Table 2 *infra* shows how supplemental insurance varies by race and ethnicity. In 1999, HMO coverage was most common for Latino elders, in part because they are more likely to reside in states with high rates of Medicare HMO coverage (California and Florida), and in part because HMOs often provide coverage for prescription medications along with low copayments and no deductibles, which is particularly attractive to low-income populations.[101] Latino elderly are also highly dependent on Medicaid to supplement their Medicare coverage (Table 2). Medicaid is important supplemental coverage because it covers prescription medications in addition to covering the copayments, deductibles and premiums required by Medicare.[102] Non-Latino whites are the most likely to have private supplemental insurance overall and over half of them have it provided by former employers (typically at little or no direct cost to the recipient). This supplemental insurance usually covers many of the expenses Medicare does not completely cover.[103] Older Latinos have a much higher rate of having no supplemental insurance than non-Latino whites, reporting neither private insurance nor Medicaid (Table 2), and therefore have the greatest exposure to out-of-pocket costs, even though they often have limited incomes.[104]

We can infer the equity consequences of this pattern of health insurance for the elderly from studies of the out-of-pocket medical expenses for elders with each type of coverage.[105] Overall, elderly people with incomes below poverty spend approximately 30–35% of their income on medical care services and premiums compared to 10% for families with incomes above 400% of poverty.[106] Elders with only Medicare who were not living in nursing homes and had no supplemental insurance spent an average of 23% of their total income on medical care expenses in 1995. The percentage would have been even higher if it was based only on discretionary income. By comparison, elders who also have employer-sponsored private supplemental insurance pay 16.1% of their incomes for medical expenses.[107] These out-of-pocket expenses are also distributed differently by insurance type, with Medicare-only elderly spending one-third the amount on dental care (which is not covered by Medicare) as those with private supplemental insurance or Medicare HMO coverage.[108] The pattern of out-of-pocket spending suggests that the inequity in financing of healthcare forces elders with only Medicare to spend more of their personal resources on hospital and outpatient services, leaving fewer resources for other heath needs such as dental care. Those with supplemental insurance who are insured against Medicare’s copayments and deductibles can devote a greater proportion of their healthcare dollar to dental and other important needs.

While the analysis of equity of financing healthcare for Latino elderly has been inferential because of the lack of Latino-specific data, their higher rates of Medicare-only insurance and lower incomes suggest that they are spending a larger proportion of their discretionary incomes on medical care than older non-Latino whites. In addition to being inequitable, older Latinos

may also have had to divert funds that might have been spent on other needed care to be able to pay for essential hospital and outpatient care.

VI. CULTURAL AND STRUCTURAL ROOTS OF INEQUITIES IN HEALTHCARE FOR LATINO ELDERS

Latino culture and the structure of U.S. social systems are the most likely root causes of inequities in healthcare system performance for Latino elders. In this Section, we discuss how culture affects the immediate behaviors of Latino elders influencing their health status and medical care use. The structures of the economy and medical care system, however, have more basic and underlying influences on inequities. The following Section discusses policy approaches to address these causes of healthcare inequities.

"Culture" is a group's shared beliefs, norms and values that can affect how individuals perceive and communicate symptoms of disease. It may also influence whom one might turn to for information and help, as well as the shared meanings about the treatment and the disease itself.[109] Culture is learned and constantly shaped by the demands of the environment on a group. Researchers offer Latino culture as a partial explanation for the advantages in mortality and life expectancy, as well as for Latino disadvantages in chronic disease and in patient satisfaction.[110]

The favorable mortality profile for Latinos has been attributed to protective aspects of culture and selective immigration.[111] Strong family ties and cultural practices associated with traditional Latino culture, "familialism," arguably encourage good health practices which protect one's health status.[112] Additionally, U.S. immigrants are healthier than individuals born in the United States,[113] indicating that the recent wave of Latino immigrants maybe contributing to some of the advantages experienced by the Latino population. This "healthy immigrant" effect may partly explain the lower mortality of the population[114] along with more favorable health behaviors found among Latino immigrants and less acculturated Latinos. Research has found, for example, that elderly Latina females who were mostly foreign-born and less acculturated than their daughters had diets lower in fat and included higher levels of fruits and vegetables than their daughters.[115] More generally, acculturated Latinos have worse diets and consume more alcohol than less acculturated Latinos.[116] These ethnic specific behaviors include reliance on family and friends for support, low-fat nutritious eating habits and low use of alcohol, tobacco and illicit drugs.[117]

While culturally patterned health behaviors have been used to explain lower Latino mortality, other health practices increase the risk of developing certain chronic disease. In particular, the high prevalence of diabetes among all Latinos has been linked to the relatively high levels of obesity found among the population. Studies consistently show that Latinos with diabetes are more likely than non-Latino whites with diabetes to be obese[118] and to have upper body obesity.[119] Overall, Latinos have risk profiles for several chronic diseases that are equivalent to, or worse than, those found among non-Latino whites.[120]

Inequities in the responsiveness of care to Latinos have also attracted cultural explanations. For example, Latinos are less likely than non-Latino whites or African Americans to make yearly physician visits or use preventive health services, such as mammographies or flu shots. Between 1997 and 1999, African American and whites used more preventative services than Latinos.[121] Some of the difference in the use of healthcare services is attributed to cultural beliefs and practices among older Latinos, such as a lower orientation to preventive care and traditional non-western medical practices that substitute for western medical care.[122] In addition, differences in satisfaction with medical care between Latinos and non-Latino whites are perhaps the result of different cultural expectations and interpretations of the medical

encounter.[123] Latinos who speak primarily Spanish are less satisfied with their care than those who speak English,[124] possibly resulting from communications barriers or different levels of acculturation.

Factors that shape the health status and care use for Latino elders are grounded in our economic structure and the structure of our healthcare system. Socioeconomic status (SES) forms the foundation for understanding health disparities including outcomes, process and financing. SES may underlie all of the major determinants of health status including access to care, health behaviors and environmental exposure.[125] Additionally, the chronic stress associated with low SES can increase morbidity.[126] Several studies find that low SES—whether measured by poverty, education or income—is linked to a higher prevalence of cardiovascular disease, diabetes, hypertension, arthritis and cancer.[127] Not only does the individual's SES affect his or her health status and services use, but the SES characteristics of the neighborhood has an independent effect as well. Persons living in neighborhoods with high levels of social disorder, poverty, crime and other socioeconomic problems are more likely to report poor health and disability than those with similar incomes living in more stable neighborhoods.[128]

The disproportionately high levels of Latino poverty, as well as their low educational levels, place Latino elders at increased risk for disease and disability. While poverty among the elderly population has declined markedly over the past thirty years,[129] Latino elderly remain overrepresented among the ranks of the poor. While the overall poverty rate of the non-Latino white elderly population is 8.1%, the poverty rate for elderly Latinos is over twice as high at 21.8%.[130] Levels of those near poverty are almost as compelling with 21.3% of non-Latino white elderly below 150% of the poverty line, compared to 42.1% for elderly Latinos.[131] As with poverty, median income also varies greatly across the elderly population by ethnic minority status and gender. The median income for elderly non-Latino white males is $20,856 and $11,929 for non-Latino white females, Latino males age 65 and older have a median income of $12,338, and Latino women have a median income of $7,585.[132]

Disparities in the sources of income are a major factor in the earnings disparities noted above, and are the result of lifetime employment patterns. Minority elderly populations are more reliant on Social Security and less likely than non-Latino whites to have income from assets and private pensions. It is estimated that while 43% of non-Latino whites have pensions from previous employers and 67% have income from assets, only 20% of Latinos have a private pension and 27% have income from assets.[133] Among the near-elderly (ages 51–61), non-Latino whites report a mean asset level of $310,765, compared to $88,821 among Latinos.[134] These differences are linked to their overrepresentation in low-wage service industry jobs and labor-intensive occupations, which do not offer pensions or other retiree benefits such as supplemental retiree insurance. Additionally, Latino elders experience educational and employment segregation, institutional racism and glass ceilings that preclude their economic advancement.[135]

These differences between non-Latino whites and Latino elderly in the use of services are only partially explained by income. Even after controlling for the level of need and a variety of other variables including income and supplemental health insurance, substantial differences remain in the use of hospital, outpatient and nursing home services.[136] While some of the differences may be driven by cultural preferences in care patterns, there are a number of unmeasured structural factors that contribute to the disparities in the use of services and satisfaction with the process of care,[137] including the structural factors that underlie the acceptability issues discussed *supra*.

VII. POLICIES TO ALLEVIATE INEQUITIES FOR OLDER LATINOS IN THE HEALTHCARE SYSTEM

To promote policy change, we must usually first raise political awareness about the problem that is the target of the policy change.[138] Since elders of color tend to be overlooked in the political process,[139] the first step in improving equity for Latino elderly in healthcare is to increase the quantity of research and publicity about the health status, process of care and financial burdens faced by this population and other elders of color. Organizations that focus on Latino health need to join with other minority group organizations that focus on health disparities and also partner with those that focus on aging to highlight these problems to a federal government that has become preoccupied with other issues.[140] Prioritizing these issues requires data on Latino elders, which will become more scarce if current proposals to strike race and ethnicity from routine government data collection are successful.[141]

Medicare is an active policy area that needs both analysis and publicity about the implications of changes for Latino and other elders of color, A slowing economy in the early 2000s and resurgent medical cost inflation is renewing interest in changing the Medicare system in ways that will reduce spending. Absent from these discussions, however, is the differential impact that the changes are likely to have on Latino and other minority elderly. A common approach to changing Medicare is to make it more like private insurance, with older persons obtaining a fixed sum that they can apply to purchasing insurance in the private market.[142] This encourages the elderly to be more price conscious by increasing the out-of-pocket costs of most older persons. Yet, as discussed *supra*, the distribution of out-of-pocket spending is already inequitable for older persons and creates disparities between older Latinos and non-Latino whites. The equity consequences of policy changes and budgetary consequences would suggest that subpopulations of the elderly in fact need increased coverage for medical care.

In addition to raising awareness of the equity issues involving Latino elders, a number of policy levers available could improve equity in the health of older Latinos as compared to non-Latino whites. The most obvious health policies and programs focusing on Latino elders address the cultural dimensions of health. Traditional health education programs concentrate on trying lo change the knowledge, attitudes and practices of populations.[143] They include attempts to make patients more knowledgeable about risk factors for diseases, more motivated to follow doctors' recommendations and more likely to use services when doctors deem it most effective. These types of programs also try lo educate individuals to change their diets, increase exercise and otherwise modify their lifestyles to improve their health independently of the medical care system.[144] A fully informed population would then be expected to balance culturally derived preferences against known outcomes, making any resulting differences between populations equitable because they were freely chosen. It has been argued, for example, that the logical target for decreasing the prevalence of diabetes among Latinos is reducing obesity through the adoption of healthy dietary habits and physical activity.[145] In fact, one of the objectives of HHS is the reduction of obesity as a risk factor for disease through a healthy diet and regular physical activity, particularly among Latinos.[146] These programs, however, risk "blaming the victim,"[147] as well as being of limited effectiveness in addressing structural causes of the patterns. They assume a relatively uniform structural context that allows freely chosen options, which we argue is not the case for Latino elders.

Health policies that focus on structural factors such as the organization and financing of medical care or the social environment where older Latinos live affect entire populations. Population-based interventions that potentially affect all elderly, such us expanding Medicare benefits, also have the potential political advantage of drawing beneficiary support that includes the middle class and politically influential individuals.

At the community level, programs that improve neighborhood safety help older Latinos feel safer when exercising, while expanding the availability of affordable fruits and vegetables provides better nutritional alternatives. Regardless of one's culture, for example, following a diabetic diet is difficult if fresh foods are expensive or difficult to obtain, as they often are in inner-city areas. New construction of large supermarkets in the inner-cities increases the consumption of fruits and vegetables by the poor.[148] Policies that encourage such construction, which may be conceptualized by some as economic development or zoning policies, are also important health policies that help ameliorate inequities.

At the healthcare system level, improving the health of the older Latino population requires changing the current healthcare delivery system to improve the process of care and to ensure that older Latinos receive appropriate levels of care. One of the main obstacles to the treatment of diabetes among Latinos, for example, is inadequate health insurance and impaired access to appropriate healthcare settings.[149] Since many diseases, such as diabetes, require ongoing medical management, reducing the out-of-pocket burdens on all low-income elders would greatly benefit the Latino elderly. Since prescription medications are the source of significant out-of-pocket costs, adding prescription benefits to Medicare would assist them, assuming that the benefits did not have significant new premiums or excessive cost sharing, Improving health insurance benefits would improve both access to care as well as the equity of financing.

Public policy can influence other important healthcare system changes including the composition of the workforce and the financial incentives within the system. Since patient satisfaction with doctors is higher when they can choose a physician of the same ethnicity,[150] equity in the process of medical care depends in part on the ethnic composition of the medical labor force. In 2000–2001, Latinos comprised 5.9% (n=887) of doctors entering medical residency programs in the United States,[151] representing half the proportion of Latinos in the general population. [152] As a result, there will be a shortage of Latino physicians for the Latino elderly to select in the foreseeable future. More policy efforts need to be directed at increasing the number of qualified and interested Latino primary school students who develop interests in becoming medical providers, in addition to fostering pathways through college and into medical schools through programs such as the Health Careers Opportunity Program.[153] Patients are also more satisfied with their care when financial incentives for the providers are tied to levels of patient satisfaction,[154] so tracking and rewarding satisfaction rates separately for Latino and other elders of color could improve the process of caring for them.

Finally, providing Latino elders with the financial resources to obtain adequate housing, nutrition and medical care would contribute to reducing many of the financing, process of care and health status inequities experienced by Latino elderly. At a minimum, the federal government should raise Supplemental Security Income (SSI), which provides need-based cash benefits to the aged, blind and disabled, to the poverty level, Few Latino elders are currently raised above poverty by SSI because its benefits are so low and because elders with more than minimal liquid assets are ineligible.[155] In addition, less than half of those eligible for SSI are enrolled in the program, even though it provides automatic Medicaid benefits.[156] For the longer term, public policy should encourage the payment of a living wage so that lifetime earnings can lead to social security and pension benefits that provide a reasonable income.[157].

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Table 1

Health status of Latino and White Persons Age 65 and Older, by Poverty Status, 2000[158]

	Latinos	White Non-Latino	Latinos, incomes below poverty line	White Non-Latino, incomes below poverty line
Percent with IADL limitations, entire U.S.*	13.4	12.1	17.6	20.0
Percent with ADL limitations, entire U.S.**	8.6	5.7	12.3	8.9
Percent reporting fair or poor health (versus excellent, very good or good) in California	44.3	24.9	62.0	43.9

* Instrumental Activities of Daily Living (IADL)—needs the help of other persons in handling routine needs, such as everyday household chores, doing necessary business, shopping or getting around for other purposes.

** Activities of Daily Living (ADL)—needs the help of other persons with personal care needs, such as eating, bathing, dressing or getting around inside the home.

Table 2

Additional Sources of Health Insurance for Non-Institutionalized Medicare Recipients*, 1999[159]

	HMO	Medicaid	Private Supplemental (Medi-Gap)	Medicare with no additional HMO, Medicaid or Private
White non-Latino	17.4%	8.1%	63.2%	11.3%
Black non-Latino	18.8%	30.9%	26.8%	23.5%
Latino	22.6%	31.2%	27.2%	18.9%

* Includes disabled persons under age 65 who receive Medicare, which accounts for approximately 13% of the total.