- In 1990, a total of 22.3 million people of Hispanic origin lived in the US
- Various Hispanic populations not only tend to live in different regions of the US but are different in educational, occupational, economic, cultural, and health background

Cross-cultural Medicine
A Decade Later

Getting By at Home
Community-Based Long-term Care of Latino Elders

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Although evidence suggests that the morbidity and mortality of Latino elders (of any Hispanic ancestry) are similar to those of non-Latino whites, Latinos have higher rates of disability. Little is known about influences on the use of in-home health services designed to assist disabled Latino elders. We examine the effects of various cultural and structural factors on the use of visiting nurse, home health aide, and homemaker services. Data are from the Commonwealth Fund Commission's 1988 national survey of 2,299 Latinos aged 65 and older. Mexican-American elders are less likely than the average Latino to use in-home health services despite similar levels of need. Structural factors including insurance status are important reasons, but acculturation is not pertinent. Physicians should not assume that Latino families are taking care of their disabled elders simply because of a cultural preference. They should provide information and advice on the use of in-home health services when an older Latino patient is physically disabled.

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Mrs Martinez is an 81-year-old widow with dementia. Her Alzheimer's disease is now at the point where she has trouble bathing and dressing independently. Although she lives alone, her daughter brings her in for medical visits and acts as a translator. The daughter has mentioned that at least two other family members also visit Mrs Martinez regularly. Born in Mexico, Mrs Martinez is a permanent United States resident with Medicare and Medi-Cal (California's Medicaid program) benefits. Should a physician discuss long-term care options with the family?

Long-term care services exist to compensate for lost (or never existing) functional capacity.[1] Yet few patients or families know about the range and availability of services in their communities.[2] Long-term care is often erroneously equated only with nursing home care. Physicians play a key role because older patients and their families commonly turn to them for information and assistance.[3]

Various factors influence the interest and ability of Latino families (of any Hispanic ancestry) to seek formal long-term care. Most of the influences can be placed into two broad categories: cultural and structural. We focus on identifying patterns of use of community-based in-home long-term care health services by Latino elders. We compare the relative importance of cultural and structural factors associated with the use of those services and relate those findings to clinical practice.

The issue of in-home care takes on increased importance when the future demographics of Latino communities are considered. First, the number of Latinos older than 65 is projected to increase by 500% by the year 2030.[4] This will increase the strain on the family and informal resources that currently provide care. Second, that strain will be compounded by the declining size of families of minority groups, further reducing the availability of informal care to the growing number of aged.

Health Status and Needs of Older Latinos

We typically discuss the health of minority populations in reference to those with the best health status in the United States, usually non-Latino whites. The status for older Latinos is mixed, however. Compared with non-Latino whites, older Latinos have better health indicators in some areas and worse in others.

A common indicator of the health status of populations is death rates. Unfortunately, ethnicity (Latino versus non-Latino) is not reported by all states and is often missing for some states that do report it. From 1979 to 1981, 13 of 15 states* that were home to about 45% of the Latino population provided usable data on Latino deaths. In those states Latinos aged 65 and older had lower death rates than older non-Latino whites for almost all causes, especially diseases of the heart (a third lower), chronic obstructive pulmonary diseases and allied conditions (50% lower), and malignant neoplasms (almost a third lower). Higher death rates occurred among older Latinos for diabetes mellitus (twice the non-Latino white rate); motor vehicle accidents (three-fourths higher);

*Arizona, Colorado, Georgia, Hawaii, Illinois, Indiana, Kansas, Mississippi, Nebraska, New York, North Dakota, Ohio, and Texas reported death rates according to ethnicity. California (which has the largest number of Mexican Americans) and Florida (which has the largest number of Cubans) did not differentiate death rates according to ethnicity.

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ABBREVIATIONS USED IN TEXT

ADL = activities of daily living
IADL = instrumental activities of daily living

nephritis, nephrotic syndrome, and nephrosis (two-thirds higher); and chronic liver disease and cirrhosis (two-thirds higher). The pattern for older Mexican Americans and Puerto Ricans was similar, except that death rates for chronic liver disease and cirrhosis were higher for Puerto Ricans and the death rates for diabetes mellitus were between those of Mexican Americans and non-Latino whites. The death rates of older Latinos average a fifth lower than those of non-Latino whites, with the Latino mortality advantage greatest among older men.[5] More complete data for 1987—18 states including California—show similar results, with heart disease accounting for an even lower proportion of the total number of deaths of older Latinos and malignant neoplasms accounting for a somewhat higher proportion.[6]

Morbidity patterns provide a similar variation in incidence of diseases. For most major diseases except diabetes, Latinos appear to have lower rates of illness than non-Latino whites. Both age-adjusted and age-specific hypertension rates are substantially lower for Latinos than for non-Latino whites,[7] contributing to a lower Latino prevalence of coronary heart disease and stroke.[8] The overall age-adjusted incidence of cancer in Latinos is also lower than that in non-Latino whites (246 versus 335 cases per 100,000 population). Latinos have a lower incidence of cancer of the breast, lung, and colon-rectum. The rate is about the same for prostate cancer, and Latinos have a higher rate of stomach cancer.[8] The most notable disease for which Latinos clearly have a higher prevalence is diabetes. Self-reported diabetes is two to three times more common among Mexican Americans than among all whites. The prevalence of diabetes increases with age, with 22.7% of Mexican Americans aged 65 to 74 reporting diabetes[9] versus 9.3% of all whites aged 65 and older.[10]

Although the death and disease patterns for older Latinos show several advantages over older whites, disability and other health indicators are worse for older Latinos. Older Latinos averaged eight more days of restricted activity from 1978 to 1980 than non-Latino whites but ten fewer days than non-Latino blacks (Table 1). Puerto Rican elders reported more restricted activity days than any group. Health status declines with income, but even when we look only at low-income elders, the pattern persists. A more severe measure of disability is the number of days that an older person is confined to bed during a year. That measure shows that both older Puerto Ricans and Mexican Americans were more disabled than non-Latino African-American or white elders. The rate of activity limitation due to chronic conditions for older Latinos was between that of older non-Latino African Americans and whites. The most commonly used indicator of general health status is self-assessed health. Table 1 shows that more than a third of older Latinos reported their health as fair or poor (versus good or excellent). This is slightly higher than the proportion of older non-Latino whites but substantially lower than the proportion of older non-Latino African Americans.

Our overall knowledge of the health status of Latino elders is complicated by data inadequacies. In general older Latinos have better health than non-Latino whites in death rates and prevalences of certain life-threatening chronic diseases. The major disadvantages for older Latinos include their higher prevalence of diabetes, their greater activity limitations, and their lower global (self-assessed) health status. Because older Latinos are disadvantaged in activity limitations, examining factors that influence the use of community-based long-term care is important.

Use of Health Care Services by Latino Elders

Although health status data indicate the potential importance of community-based in-home health services, most of the research on health care use by Latino elders has focused on the use of physicians and hospitals. In both areas older Latinos appear to receive similar or more care than older non-Latinos. Older Latinos have more physician visits per year than either non-Latino whites or African Americans (Table 2). This pattern holds even for those reporting poor or fair health. Less variation occurs in the rates of hospital admissions, although older Latinos are slightly more likely to use a hospital than older non-Latino whites or African Americans.

A different pattern emerges when we control for factors that influence physician and hospital use among middle-aged and older Latinos. Puerto Ricans and Mexican Americans are more likely than non-Latino whites or African Americans to see a physician as their physical activity becomes limited, even after controlling for age, sex, health status, and other factors. On the other hand Puerto Ricans and Mexican Americans are less likely to be admitted to hospital when they rate their health as poor.[13]

Limited data exist on the use of long-term care services by Latino elders. Most data show that older Latinos are less likely than either older whites or African Americans to use

TABLE 1.—*Health Status of Latinos, Non-Latino Whites and Non-Latino African Americans Aged 65 and Older*

Health Status	*All Latinos*	*Mexican Americans*	*Puerto Ricans*	*Non-Latino Whites*	*Non-Latino African Americans*
Restricted activity, days/person/yr*	46.5	52.8	61.4	38.7	56.9
Restricted activity in families with income <$10,000/yr, days/person/yr*	55.0	58.8	84.0	45.4	62.5
Bed disability, days/person/yr*	20.7	26.1	35.7	12.9	22.9
Activity limitation due to chronic condition, % of persons*	47.5	52.4	52.6	44.3	57.2
Fair or poor self-assessed health, % of persons†	35.2	32.0	37.5	29.0	46.8

*Data are from 1978 to 1980.[11]
†Data are from 1987.[12]

TABLE 2.—*Use of Health Services by Latinos, Non-Latino Whites, and Non-Latino African Americans Aged 65 and Older**

Health Service	All Latinos	Mexican Americans	Non-Latino Whites	Non-Latino African Americans
No. of physician visits/person/yr.	8.2	9.1	6.3	6.7
No. of physician visits for those with fair or poor self-assessed health/person/yr	11.5	12.1	9.6	8.9
≥1 Hospital episodes, % of persons	18.7	18.5	18.3	17.3

*Data are from 1978 to 1980.[11]

nursing homes,[14,15] even after other risk factors are taken into account.[16] The higher level of disability for Latinos in the community may be partly because disabled Latinos remain in the community when similarly disabled whites use nursing homes.

In-home health care is viewed as an alternative to institutionalization, but we know little about the effects of race, ethnicity, culture, and class on the use patterns of community-based and informal long-term care services.[17] Older Latinos and non-Hispanic whites use paid in-home care in about the same proportions nationally, whereas older Latinos receive more informal care.[18] This does not, however, control for level of disability, availability of family, financial status, or other factors that might increase or decrease the need for formal and informal care.

A study of case-management clients in Arizona found that older Latinos were less likely to use community-based long-term care services than non-Latino whites despite their greater activity limitations.[19] The lower level of formal support received by Latino elders was balanced, however, by higher levels of informal support. Greene and Monahan caution that their data do not indicate whether the family support was provided because formal support was not available or in preference to formal services. This distinction between service use patterns as a result of preferences versus barriers in the structure of the health care system forms the core of the debate over differences in the use of health services by minority elders.

Culture and Institutional Structure Influencing Health Care Use

Forces that influence the use of health services by minority elders can be divided into two general categories: cultural and structural. Cultural influences include the belief systems, behaviors, and preferences of a group that might cause certain patterns of health care use. Structural influences include the way the health care system and other social institutions are organized and operated. They may present both incentives and barriers to the use of health services.

Culture. Cultural influences would be expected to shape the use patterns of long-term care, especially because long-term care often involves nontechnical assistance that can be provided by family members. Culture may influence the use of family versus paid care through concepts of family responsibility and attitudes toward the use of public services for those eligible for Medicaid. The strength and centrality of family are common Latino values.[15] A possible explanation of why Latino elders use nursing homes less often than do non-Latinos is that Latino family roles make Latinos more disposed than non-Latinos to make the sacrifices necessary to help older relatives.[20]

Culture can also influence how satisfied patients are with their medical care. Health care professionals' lack of knowledge about Latino cultural norms and inability to communicate in Spanish are often cited as factors discouraging Latinos from seeking needed health care.[21-23] Acculturation—an immigrant's adoption of attitudes and common behaviors from the dominant society—can affect both family functioning[24] and health service use.[25] It is surprising, therefore, that most research on health care for Latino elders has not expressly investigated the importance of acculturation (others[26] also note this deficiency). Although acculturation does not necessarily weaken Latino family functioning overall,[27] there is evidence that acculturated families provide lower levels of informal support to the aged.[28] Thus, we might expect acculturated Latino elders to use more formal services than traditional Latino elders.

Institutional structure. Income and health insurance are the most important structural determinants of a person's ability to obtain health care. Older Latinos are disproportionately poor because of the structure of our occupational and economic system. Also, our health care system rations care based on ability to pay. Almost all older people have insurance coverage for acute care from Medicare, but Medicare pays less than 6% of all long-term care costs in the United States.[29]

Given the importance of income and insurance in determining long-term care use, there is a major gap in the health insurance status of Latino elders. In the general population many more Latinos are uninsured (33%) than whites (13%) or African Americans (19%). This is largely because Latinos are concentrated in industries such as personal services and construction that do not offer insurance and because they disproportionately live in states—Texas and Florida—with stringent Medicaid eligibility criteria.[30] As a result, serious illness in the family is considered a financial problem almost twice as often among Latinos as other whites (39% versus 19%).[31]

Retrospective Study

The following analysis reports on the use of in-home health services for all older Latinos and for specific Latino subgroups. Their use of services is examined by need, individual characteristics, family status, acculturation, and health insurance.

Methods of Analysis

The data were from the 1988 national survey of Hispanics aged 65 and older sponsored by the Commonwealth Fund Commission on Older People Living Alone. Telephone interviews, done primarily in Spanish, were conducted of 937 Mexican Americans, 714 Cuban Americans, 368 mainland

Puerto Ricans, and 280 other Hispanics.* The data were weighted to reflect US population estimates. The survey contractor's final report contains a complete methodologic discussion.[32]

We were primarily interested in explaining the previous year's use of in-home health services (home health nurse, home health aide, or homemaker). We focused on these services for two reasons. First, these services are often covered by Medicaid, Medicare, or both, and target the most disabled elders. Second, physicians are central to these services because physician certification of need or a care plan is required before Medicare or Medicaid will pay for them in many situations. Even when physician approval is not necessary, physicians can be an important source of referrals.

Explanatory variables include five health status indicators as evidence of need for in-home services: limitations in activities of daily living (ADL)—bathing or showering, dressing, transferring, walking, getting outside, using the toilet; limitations in instrumental activities of daily living (IADL)—preparing own meals, managing money, using the telephone, doing light housework, doing heavy housework; self-assessed health status; hospital admission within the past year; and frequent physician visits in the past year.

*The largest nationality was Dominican (95 interviewees) followed by in decreasing frequency Spanish, Colombian, Salvadoran, Ecuadoran, Nicaraguan, and 15 other nationalities.

Demographic and social characteristics are often associated with differences in the use of health services. We examined the demographic variables of sex and age. Social level variables are subject to intervention and change. They include indicators of traditional culture (acculturation), education, social support (living alone, living with spouse, living without spouse but with or near children), income (poverty), and health insurance.

Two variables are frequently used to indicate levels of acculturation: language ability[21,33] and age when the respondent arrived on the US mainland.[34] We created a summary variable that includes both of these dimensions and can be interpreted as the extent of acculturation of the respondent in comparison to the average level of acculturation (low) of all older Latinos.

Results

Needs and resources of Latino elders. The need for in-home health services for older Latinos appears to be substan-

TABLE 3.—*Characteristics of Latinos Aged 65 and Older by Subgroup**

Characteristic	*All Latino Elders,† %*	*Mexican American, %*	*Cuban, %*	*Puerto Rican, %*	*χ^2 Statistical Significance‡*
Health					
1 or more ADL difficulty	39.1	39.6	32.0	44.6	.005
1 or more IADL difficulty	53.4	54.5	44.8	54.3	.005
Self-assessed health—fair or poor	53.3	57.0	46.7	62.7	.000
Hospital use past year	22.1	20.7	21.5	31.8	.001
Physician use ≥ 12 times past year	23.9	20.5	28.8	36.7	.000
Demographic					
Women	55.9	53.2	61.7	55.8	.019
Aged 65-74 yr	62.1	62.3	54.7	69.5	.001
Social					
Immigrated at age 55 or older	16.0	6.2	41.4	13.1	.000
Immigrated at age 31-54	21.2	10.6	49.8	40.4	
Immigrated at age 17-30	12.1	12.4	5.3	34.2	
Immigrated at age 0-16	12.4	17.9	3.0	12.3	
Born in US/mainland	38.4	52.9	0.5	0.0	
No English (monolingual Spanish)	39.4	33.8	57.3	37.4	.000
Poor English§	32.5	37.4	30.6	37.3	
Speaks English well	28.1	28.7	12.1	25.3	
<5 yr school	42.5	54.3	17.1	41.5	.000
6-11 yr school	38.7	33.8	49.1	45.1	
High school graduate and up	18.7	12.0	33.8	13.4	
Lives alone	22.4	22.3	23.1	26.2	>.05
Lives with spouse	48.7	50.0	44.6	46.5	>.05
Without spouse, lives with children or within 30 min	36.6	38.1	33.5	35.6	>.05
Family income					
Above poverty	31.9	29.8	37.6	30.5	.005
Below poverty	42.2	45.1	35.8	41.8	
Unknown or refused	25.9	25.1	26.6	27.7	
Covered by Medicare	79.9	79.6	87.3	79.8	.007
Covered by Medicaid	42.2	39.0	52.8	50.7	.000

ADL = activities of daily living, IADL = instrumental activities of daily living

*Weighted to reflect United States population estimates for older Latinos.
†Includes "other Hispanics," not presented separately.
‡Significance of χ^2 comparisons among three subgroups is given.
§Primary language is Spanish and reports fair or poor English ability.

tial but varies among the groups. In general older Puerto Ricans have the highest levels of need, followed by Mexican Americans and Cubans. More than a third of all older Latinos had one or more difficulties in ADLs, more than half had one or more difficulties in IADLs, and more than half reported fair or poor health (Table 3). More than two fifths of all older Latinos had a hospital admission, and more than two fifths saw a physician at least 12 times during the past year. Older Puerto Ricans had the highest use of medical services. The high ADL and IADL dependencies, the low self-assessment of health, and the common use of physician and hospital care reinforce the data presented earlier showing a high need by Latino elders for community-based long-term care.

The older Latino population includes more women than men, with most elders in the "young elderly" range (ages 65 to 74). The Cuban population had even more women and were older, reflecting their different history of migration to the United States.[35]

Some social characteristics (Table 3) are liabilities for those needing supportive services, including recent immigration, limited English, low education, and poverty. Only half of the Mexican-American elders and almost no Cuban or Puerto Rican elders reported being born in the United States. A sizable proportion, especially Cubans, immigrated at age 55 and older. Almost 40% of older Latinos reported speaking no English, even though more than a quarter reported good English skills. Almost half of the older Latinos had less than a primary school education. A third of older Cubans, however, were high school graduates. Poverty is a common problem that is most acute among Mexican-American elders.

Resources for disabled Latino elders potentially include health insurance and the availability of family. Most older Latinos live with a spouse or without a spouse but with or near (within 30 minutes of) their children. The living arrangement is the only characteristic where there are no statistically significant differences between the Latino subgroups. Although most older Latinos have Medicare, the proportion without coverage is twice the national average.[32] On the other hand older Latinos have high rates of Medicaid coverage, partly as a result of their high poverty rates. Mexican-American elders, however, have the highest poverty rate and the lowest Medicaid rate.

Characteristics of each group reflect its immigration and occupational history. Older Mexican Americans are most likely to have been born in the United States but have had limited occupational opportunities and have faced housing discrimination.[35] Among this group, for example, 21% reported farm work as their primary lifetime occupation.[32] This history explains why older Mexican Americans have the lowest educational levels, only average English abilities, above-average poverty rates, and incomplete Medicare coverage (Table 3). In addition, some older Mexican Americans avoid government programs, such as Medicaid, and services because they are undocumented residents. In the 1986 immigration legalization program, 1% of Mexican immigrants applying to regularize their status were aged 65 or older.[36] In contrast, older Cubans include many professionals who immigrated as adults after the end of the Cuban revolution in 1959.[37] Consequently, Cuban elders have the most education, the least English ability, and oldest ages at the time of immigration. They can receive Medicaid because of their special refugee status.[38] Puerto Ricans are like Mexican Americans in most social characteristics, although no Puerto Rican elder in this survey was born on the mainland. Puerto Ricans, however, are all US citizens as a function of the commonwealth status of Puerto Rico and therefore never face immigration status barriers to the receipt of Medicaid.

Use of services. Given the high levels of disability among the Latino elders, we expected to find high levels of service use. Table 4 shows the high use of community services, with some differences by subgroup. Visiting nurses were the most commonly used in-home health service, followed by homemakers and then home health aides. The higher use of most in-home health services by older Puerto Ricans mirrors their higher levels of disability and poorer health. Mexican-American elders use in-home health services less than Cuban elders in two of the three services, but this lower use does not reflect any health status differences. It is important to note that each population is concentrated in different areas: Puerto Ricans in New York City, Cubans in Florida, and Mexican Americans in the Southwest. Some of the differences in use may have resulted from differences in the availability of services in the different areas.

TABLE 4.—*Use of 3 Different In-home Health Services in Previous Year in Older Latinos by Subgroup, 1988**

Health Service	All Latino Elders,† %	Mexican American, %	Cuban, %	Puerto Rican, %
Visiting nurse‡	9.3	8.6	9.9	15.9
Health aide§	5.1	4.1	6.7	7.0
Homemaker‖	7.2	6.0	9.0	14.2
Any in-home health service§	14.8	13.2	18.4	22.0

*Sample data were weighted to reflect United States population estimates for older Latinos.
†Includes "other Latinos" not presented separately.
‡Puerto Ricans differed from other 2 groups at $P<.05$; no statistically significant difference was seen between Mexican Americans and Cubans.
§Mexican Americans differed from other 2 groups at $P<.05$; no statistically significant difference was seen between Cubans and Puerto Ricans.
‖All between-group differences were significant at $P<.05$.

Correlations show the relationships between the use of in-home health services and the needs, individual characteristics, and social characteristics of each subgroup of Latino elders (Table 5). For correlations that are statistically significant, we need to compare the size of the correlations to determine the practical relevance. In particular, the correlations show the relatively high importance of need factors and Medicaid and the relatively low importance of cultural factors.

The need indicators of ADL and IADL disability have the largest correlations with the use of in-home health care (Table 5). Medical care use—hospital and frequent physician care—has smaller but important correlations with the use of in-home health care. The only other correlations similar in magnitude to the need indicators are advanced age and receipt of Medicaid. Smaller correlations include the negative relationship—decreases the chance of service receipt—between living with a spouse and in-home health services. For Mexican-American and Puerto Rican elders, living alone increases the chance that services will be used.

As we would expect, ADLs, IADLs, and being admitted to a hospital are each predictors of in-home health service use. Part of the role of visiting nurses, homemakers, and home health aides is to assist the disabled elderly with ADLs and IADLs or other needs those impairments might create.

Similarly, the push to discharge the elders from hospitals as early as possible has moved some of the care formerly provided in the hospital into the home, increasing the need for posthospital nursing and other care.[39] Further analysis, not presented here, found that self-assessed health and physician visits did not predict the use of in-home health services after controlling for other variables.[40] Both a global assessment of health as poor and frequent physician visits can be the result of a variety of health conditions not related to a disability that requires long-term care. Consequently, older Latinos who use in-home care are more likely than non–in-home care users to see a physician (the correlation), but physician use itself does not increase the use of in-home health services.

Mexican-American and Cuban men are somewhat less likely to use in-home health services than women (Table 5) because they are generally younger than the women and more likely to be living with a spouse. Gender by itself does not influence the use of in-home health services.[40] Frail older Latinos (age 75 and older) are more likely to use in-home services independent of need and social factors.[40] Age may increase the number and severity of disabilities (we only measured their presence) or weaken informal support (for instance, an aging spouse may no longer be physically able to provide the same level of assistance), or both.

TABLE 5.—*Correlations of Use of In-home Health Services by Older Latinos by Subgroup, 1988**†

Characteristic	*All Latinos*	*Mexican Americans*	*Cubans*	*Puerto Ricans*
Need indicators				
ADL (1 or more)	.30	.29	.28	.36
IADL (1 or more)	.27	.25	.33	.33
Self-assessed health—1 = fair or poor, 0 = excellent or good	.17	.18	.18	.12
Hospital admission past year—0 = no, 1 = yes	.28	.25	.26	.23
Frequent physician use 1 = ≥12/yr	.13	.11	.11	.23
Individual characteristic				
Sex—0 = female, 1 = male	−.08	−.11	−.12	−.09†
Age, yr—0 = 65-74, 1 = ≥75	.23	.24	.24	.24
Social characteristic				
Acculturation	−.04	−.01†	−.05†	−.10†
Education—<6 yr, 6-11 yr, 12 yr and up	−.05	−.03†	−.06†	−.18
Live alone—0 = no, 1 = yes	.12	.17	.02†	.15
Live with spouse—0 = no, 1 = yes	−.11	−.09	−.13	−.15
Live without spouse and with or near children—0 = no, 1 = yes	.02†	.01†	.02†	.02†
Family poverty—0 = no, 1 = yes	.09	.10	.01†	.19
Medicare—0 = no, 1 = yes	.09	.07†	.00†	.16
Medicaid—0 = no, 1 = yes	.20	.17	.19	.17

ADL = activities of daily living, IADL = instrumental activities of daily living

*Sample data are weighted with the normalized weights.
†All correlations are significant at $P<.05$, except those with †'s, which are not statistically significant.

As we expected, we also found correlations between in-home health care use and some of the social resources. Living alone, which indicates a lower level of available support, increases the chance of using in-home health services for most subgroups. Accessibility to family help, as indicated by living with a spouse, reduces the use of in-home services. When other variables are controlled, living without a spouse but with or near children also reduces the use of in-home health services.[40] What the data do not show is the causal order—whether family is used in preference to formal services or because formal services are unknown or unavailable. Latino elders with Medicaid coverage are more likely to use services,* demonstrating the importance of financial barriers to in-home service use. Medicaid can pay for in-home health services, reducing the financial burden for low-income Latino elders.

The small and not statistically significant correlations with some variables are as important as the larger correlations just described. In particular, acculturation has an unexpectedly small or not significant correlation with the use of in-home health services (Table 5). Similarly, despite the emphasis on family in Latino culture, the accessibility of children for those living without a spouse had no statistically significant correlation with the use of in-home health services. Acculturation, which was measured by knowledge of English and age at immigration, had no relevant correlation with in-home health service use. Even when controlling for other variables, acculturation remained not significant. Similarly, graduation from high school had no independent effect on the use of in-home services.[40] The lack of any overall acculturation effect supports the conclusion that family support is not primarily a result of a strong cultural preference for family help. Cuban elders had few significant correlations of social characteristics with service use.

After controlling for all the other variables, Puerto Rican elders are still twice as likely to use in-home health services as the other Latino groups.[40] This is possibly because older Puerto Ricans commonly live in New York City, which has a relatively well-developed network of in-home services compared with other parts of the country (V. Levy, New York City Department for the Aging, oral communication, November 1991). Similarly, Mexican-American elders may have lower in-home health service use because some live in nonurban areas and in states where fewer services exist.

Summary

Latino elders comprise a diverse set of subgroups.† Our data show that all subgroups frequently have functional limitations and low health status, with Puerto Ricans having the worst health. Acculturation has little or no effect on the use of in-home health services for any subgroup, whereas structural factors such as health insurance and the local availability of services have a moderate effect on all subgroups. These structural factors are the most likely reason that Mexican-American elders use in-home health services less than the other subgroups.

Structure or Culture—What Does It Matter?

In an ideal health care system, the use of services would be determined only by need and personal preferences. Our data show that need factors are among the strongest predictors of the use of in-home health services. We consistently

*The increased chance of use by those in poverty is mostly caused by those in poverty being more likely to have Medicaid, to live alone, and to have ADL or IADL limitations, each of which independently increases the use of in-home health services.

†There were not enough Central Americans in the sample to form any generalizations, but those living in the Southwest probably have many characteristics similar to Mexican-American elders: a significant proportion will be undocumented residents, and most will have low incomes, low Medicaid coverage, and low in-home health service use. Few will have been born in the United States.[41]

found, however, that health insurance status and living arrangements also influence the use of in-home health services. If we are to ensure that Latino elders receive appropriate health services, we need to understand the extent to which structural and cultural forces are also involved in the use of services.

The importance of living arrangements—especially after other factors are taken into account—could be described as the result of a cultural preference for family help in place of formal assistance. Acculturation has no significant effect, however, which contradicts the interpretation that reliance on family in place of formal in-home health services is a simple cultural preference. The more likely explanation is that families could use and benefit from the extra help provided by in-home health care, regardless of their cultural orientation. Latino elders, their families, and all other elders, however, generally have a low awareness of the existence and purpose of in-home health services.[2,3] Their low-income backgrounds make them less likely to think that paid help is feasible.

A moderate use of physician services did not independently increase older Latinos' use of in-home health services, despite the fact that the physicians are the most common source of information about long-term care in the general population.[3] If most physicians assessed the disabilities of the older Latino patients they see often and made referrals to in-home health services when indicated by need, we would expect to see physician visits independently associated with increased service use.

One reason physician visits may not increase in-home health services use is that many physicians may observe the family providing in-home assistance and assume that such assistance is provided for cultural reasons. It is possible, however, that the family assistance is provided because the elder and the family are not aware of the range of options available or are deterred by the complexity of the long-term care system and its financing. Families may also think that because care giving has not yet become a crisis, it is not appropriate to ask for additional help. For Latino elders who have Medicaid and therefore access to a case manager, it would be helpful for physicians to assess the functional disability level of their patients and counsel their disabled older Latino patients about the range of community services available to supplement the care they may already be receiving from their families. Research on the general older population finds that formal services complement rather than replace the efforts of family.[42] Older Latinos often hold expectations of assistance from their families,[21,43] but those expectations do not mean that formal services would not improve the status of the elders and their care givers or that in-home health care would be refused if offered.

For Mrs Martinez (opening paragraph), the physician should discuss the availability of Medicaid and other homemaker services as an option for providing some of the basic care that she needs. A homemaker could help Mrs Martinez get up, bathe, and dress in the morning, thereby allowing the family to continue providing other ADL, IADL, and emotional support. Because the steadily deteriorating nature of Mrs Martinez's dementia will place increasing demands on her family support system, the formal assistance might help prevent the family support from becoming prematurely overwhelmed.

We should also not ignore the role of culture in the care of Latino elders. Attention to cultural values such as respect, the involvement of family members in health decisions, and use of the Spanish language have been shown to be important aspects of the quality of care for Latinos.[21,44,45] Attention to culture should not divert health care professionals from ensuring that older Latinos have the opportunity to receive in-home health services when their physical condition merits it. For Mexican-American elders especially, who face the most structural barriers to the receipt of care, physicians should make an effort to ensure access to needed visiting nurse, home health aide, and homemaker services.

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IN APRIL, HEARING THE NEWS

it's before being
a hostage to
loss and dying
numbs and each
word is charged
and when my mother
tells me I'm so
pretty as I see
her sit down
in Sears looking
lost then looks
up at me and
waves as she does
from the other
twin bed when I
can't tell since
she often sleeps
with her eyes
open if she's
sleeping and I
wasn't drained
from staying 11
weeks in a house
that's a cage is
full of cages as
my sister tries to
jail everything
that should breathe
before the night
mare of living
in a house in
enemy territory
was the price
for having
her still

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