Research Note

Elderly Mexican Americans: Nativity and Health Access

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Information from the 1976 Survey of Income and Education are used to explore nativity differences in the levels of functional impairment and access to some kinds of medical resources among elderly Mexican Americans. The data indicate that foreign-born status is weakly associated with greater functional disability. It is more strongly associated with some differences in access to medical resources. Some implications for policy and long-term care are discussed.

Hispanics are currently the fastest-growing ethnic minority in the United States. They increased from 2.7 percent to 6.4 percent of the population in the thirty-year period spanning 1950-1980 (Davis, *et al.*, 1983:8). With their growth in numbers, concern over the health status of this group has increased. Dangerous occupations, low incomes, low educational levels, and linguistic difficulties are thought to produce greater health problems and less access to adequate medical care for Hispanics as a group than characterizes the general population.

Documentation of specific health-related problems of Hispanics has proved to be difficult, however. The inclusion of their vital statistics under the general heading, "white", has made important data inaccessible. Cumbersome and time consuming methods of identifying Hispanics in U.S. Census counts have also discouraged extensive health surveys of this population (Baily, 1983). Recent attempts to overcome these difficulties, such as the 1978-1980 health interviews done by the National Center for Health Statistics (NCHS) and surveys undertaken by the *Association Nacional Pro Personas Mayores* (ANPPM), have begun to produce data that can be used to improve services and guide policy.

From these data and others (*e.g.*, Schur, *et al.*, 1986), it has become evident that the general designation, Hispanic, masks important ethnic variations in the health-related characteristics of the Spanish-speaking population. Mexican, Puerto Rican and Cuban subgroups in the United States differ significantly in their age structures, immigration histories, and sociodemographic characteristics. The extent to which these differences are associated with differences in health status is suggested by National Health Survey findings

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that over the 1978-1980 period, the incidence of acute conditions ranged from 172.5/100 for persons of Cuban origin to 321.8/100 for persons of Puerto Rican origin (National Center for Health Statistics, 1984:12).

It is only through more detailed anaylses of these subgroups that real progress can be made in providing adequate health care to the population in both an equitable and a cost-effective way. According to Trevino and Moss (1983:45),

> The ability of the Nation's health care system to effectively serve the ever-increasing health needs of Hispanic Americans will depend to a large degree on a sound body of data regarding their health status, use of services, unmet health care needs and health resources available to them.

Older Hispanics are of particular interest because the elderly command medical resources out of proportion to their numbers. For example, in the federal budget for fiscal year 1983, Medicare accounted for almost 64 percent of the estimated outlays for health-care services (Office of Management and Budget, 1983:5-130). The elderly are hospitalized twice as often as the younger population and use twice the number of prescription drugs (Tauber, 1983:16). Therefore, the health status of older persons figures importantly in any assessment of the health needs of a group. Information on older Hispanics will be even more important as the gap between Hispanic and non-Hispanic fertility narrows and the hispanic population begins to age.

In spite of the possibility that there are greater health problems and fewer resources among older foreign-born Hispanics than among those who were born in the U.S., research has generally failed to consider nativity as a factor contributing to health status. In an effort to address such oversight, this article explores two facets of the question of the impact of nativity on the health status of elderly Hispanics who identify themselves as Mexican or Mexican American. The first half of this work looks at nativity differences in functional disability while the second half describes nativity differences in access to some kinds of medical resources.

Nativity is a variable which is believed to impact on health status. In general, being foreign-born is associated with lower income, educational, and occupational status (Keefe, *et al.*, 1979; Padilla and Keefe, 1984; Keefe, 1982). These are the kinds of characteristics that have been found to be generally linked to poorer health and fewer medical resources. The potential importance of nativity for understanding the health status of Hispanics is obvious, since immigration has played such an important part in the growth of this population.

Mexicans comprise the largest of the Hispanic migrant streams. In the two decades of 1950-1970, Mexicans accounted for 40 percent of Hispanic migration (Davis, *et al.*, 1983:22). In 1980, Hispanics who identified themselves as Mexican or Mexican Americans made up 59.8 percent of the Hispanic

population of the U.S. (Davis, *et al.*, 1983:9). While their influence is more directly felt in the five states where they are concentrated (Arizona, California, Colorado, New Mexico and Texas), they have an impact on the nation via federally supported programs such as Medicaid.

NATIVITY, HEALTH STATUS, AND MEDICAL RESOURCES

Background

Research into the health status and medical resources of Hispanics has been slow in coming. Much of the literature in the area has inferred poorer health and less access to resources among Hispanics because low educational and income levels are associated with greater health problems and less use of conventional medical services in other groups. Foreign-born Hispanics are even more likely to have a lower socioeconomic status than the general population (Keefe, *et al.*, 1979; Keefe, 1982; Padilla and Keefe, 1984). For this group, factors such as poor command of the language, inability to prove resident status, and failure to qualify for entitlement programs have been assumed to be additional barriers to optimal medical care (Bell, *et al.*, 1976:40-43; Stanford, 1980:305-306).

Empirical evidence on the health status of Hispanics has tended to come from small-scale and highly localized studies. Socioeconomic status and ethnicity have received most of the attention as factors associated with variations in health and the use of medical services. Little of this literature has focused on older Hispanics, but some generalizations are beginning to emerge. By and large, the risk profiles of elderly Hispanics are similar to those of older Anglos (Stanford, 1977:54; Vallbona, 1984:12). Arthritis, hypertension, and caridovascular problems head the list of serious chronic conditions for the elderly, regardless of their ethnic identity. There are, however, some differences in the extent to which Hispanic subpopulations suffer from specific health problems. For example, the ANPPM survey (1980) found diabetes to be more common among Mexican Americans than among Cubans. In contrast, Bean and Frisbie (1978), in their Texas study, found lower mortality from cancer and circulatory diseases among Mexicans than among the general population.

In addition to disease and physical impairments, another indicator of health status that is widely used is some measure of how a medical condition affects daily functioning. These measures of functional disability, or functional impairment, recognize that health is more than the absence of disease. The ability to work, to engage in leisure activities and to care for oneself is also influenced by perceptions of what constitutes good health, the kinds of jobs and nonwork activities done, the demands of friends and associates, and the extent of social and economic well-being.

Data on ethnic differences in functional disability indicate that Hispanic groups report more functional disability than Anglos, although the magnitude of the difference varies somewhat from sample to sample. According to information from the National Health Survey (National Center for Health Statistics, 1984:50-51) older Mexican Americans are somewhat less likely (52.4%) than older blacks (57.2%) but more likely than older Anglos (44.3%) to report limitations on activity produced by chronic conditions. This pattern was also found in a smaller-scale study by Roberts and Lee (1980).

It is difficult to give medical interpretation to differences in functional disability. A report that one suffers from some limitation in activity may mean anything from being bedridden to being unable to continue former athletic activities. Ethnicity only adds to the ambiguity of these kinds of data. The consistent finding that non-Anglo minorities are more likely to experience physical impairment in old age than Anglos is disturbing but not particularly helpful in designing services or setting policy, and the failure of studies to differentiate between immigrants and the U.S.-born also eliminates information which could help focus health-care services.

The question of how well the health-care system serves minorities has two parts: To what extent are existing services utilized? and, How well do these services meet the health needs of their minority participants? Most of the research in this area has centered on the first part. Research on service utilization indicates more than anything else how little we know about the health needs of older Hispanics and the factors which affect their use of services. There is research indicating that Mexican Americans underutilize health services such as hospitals and public-health clinics (Morrison, 1983:165; Stanford, 1977:54; Valle, 1983:69; Walker, 1979). There are, however, studies which indicate that if such services are made more accessible through mechanisms such as third-party payments, then their use approaches, or even exceeds, the rates of the general population (Mechanic, 1972; Montiero, 1973; Rabin, *et al.*, 1974). It has also been demonstrated that Mexicans and Anglos alike prefer to receive medical care from private physicians (Morrison, 1983; Welch, *et al.*, 1973). Once income and education are held constant, some studies indicate little if any significant difference between Anglo and Mexican use of this source of health care (Galvin and Fan, 1975; Roberts and Lee, 1980; Welch, *et al.*, 1973).

Nativity has received some attention as a factor in the use of medical services. Localized studies indicate that Mexican immigrants tend to underutilize medical services with the exception of hospital services (Young, 1979; Walker, 1979; Bullough and Bullough, 1982; Keefe, 1982). Chavez, *et al.* (1985) found that Mexican immigrants in their San Diego county sample used medical services ranging from private physicians to hospitals and clinics on both sides of the U.S.-Mexico border. While private physicians were preferred souces of medical care, hospitals and clinics taken together

accounted for more than half of the care received. They did not report comparisons between the foreign and the native-born.

What these general patterns mean for the health care of older Hispanics is uncertain. Some of the dynamics of service utilization can be inferred from NCHS data. For example, the importance of perceived illness in prompting the use of medical services is indicated by the fact that the number of physician visits was larger among elderly Mexicans reporting fair-to-poor health than among those reporting excellent-to-good health. Furthermore, numbers of visits were somewhat higher among Mexican Americans than among non-Hispanic whites at both health levels (NCHS, 1984:22).

Patterns are similar for hospital stays. Slightly larger percentages (48%) of Mexican American elderly than of Anglo elderly (44.2%) reported short hospital stays over a twelve-month period, but the percentages reporting stays of two weeks or more were virtually the same — 30 percent *vs.* 29 percent (NCHS, 1984:38).

Whether or not these differences mean that Mexican American elderly were receiving health care commensurate with their needs cannot be determined without a much more accurate picture than now exists of the incidence of specific diseases and medical conditions.

Clearly, the study of Hispanic health issues has only begun. More data are needed on the variations that exist among the various Hispanic subgroups. Within each subgroup, age and sex variations in health needs and service use have yet to be systematically investigated. The part that nativity plays in health status and service use is also an important but neglected line of inquiry.

In addition to some obvious gaps in the picture of Hispanic health needs, there are a number of other issues that need to be addressed. One of these is the relationship between ethnicity as culture and ethnicity as social class. Some research has suggested that it is the low socioeconomic status of Hispanic elderly which accounts for their greater health problems (Roberts and Askew, 1972; Roberts and Lee, 1980; Stanford, 1977). For example Cantor's (1979) sample of inner-city minority elderly reported both more ill health and lower income among Hispanic (primarily Puerto Ricans) then among the black elderly subsample. Similarly, mortality figures from Texas and California (with Hispanic populations which are primarily Mexican) show Hispanic life expectancy rates to be higher than those of blacks (Soldo and Vita, 1977), consistent with their higher median incomes in those states.

It can be argued that the cultural component of ethnicity is as important as its inequality component for determining some health-relevant patterns such as diet. The relationships among these variables must be specified, and nativity needs to be factored into the equation because it contributes to both the cultural and inequality aspects of ethnicity.

Another set of issues involves the measures of illness/wellness that are

pically used. For example, at the present time there is heavy reliance on lf-reports of disability and level of functioning of the elderly. The health roblems of old age are primarily chronic conditions, some of which may imit mobility and functioning without representing problems calling for egular medical intervention. The problem with these measures, however is hat while there is generally a positive relationship between self-assessed ealth and physician-rated health (*e.g.*, Freidsam and Martin, 1963; Maddox nd Douglas, 1973), Linn, *et al.* (1980) found little or no correlation between unctional limitations and "organ impairment" as determined by a physician.

This article addresses itself to the question of whether or not nativity is associated with significant differences in health-related characteristics of elderly persons who identify themselves as Mexican. Specifically, it investigates the possibility that there are significant nativity differences in the ability to function independently and in access to certain kinds of medical resources.

Data and Methods

The data used for this study come from the Survey of Income and Education (SIE) done in 1976 by the United States Bureau of the Census. The survey was done as a supplement to the 1976 Current Population Survey and was designed to give detailed information on the numbers of children living in families with incomes below the poverty level.

These data represent information from 151,170 households sampled in a stratified, fifty-state cluster design. They were gathered in personal interviews with adults who represented the household. Basic household information and personal information on each household member were obtained in this manner. Because the majority of the older people and older families sampled in this survey lived in households independent of other family members, information on older individuals came from the individuals themselves or from spouses, not from other family members.

In addition to detailed breakdowns of ethnicity for the families and individuals sampled, the survey also included a number of health-related questions. Among these were questions indicating degrees of functional disability, the specific conditions responsible for the limitation, the kinds of medical coverage possessed and whether or not the respondent had received benefits from one of several public health services in the past twelve months. These measures of functional disability are not assumed to be analogs of illness but rather indicators of social and physical dependency.

The subsample used in this analysis is made up of 463 persons who indicated that they were of Mexican origin. They are compared with 4,209 non-Hispanic whites and 3,401 blacks for a total of 8,073 persons. While the ethnic subsample in this data set is too small to allow the simultaneous consideration of multiple variables, the data do represent an advantage over

previous samples in that they are drawn from a national pool. This data set also represents an advantage over the more recent HHANES because it allows Hispanic — non-Hispanic comparisons. Furthermore, we feel that inasmuch as poverty levels and age compositions of Hispanic groups have changed little since these data were gathered (U.S. Bureau of the Census, 1984) they can still provide us with valuable information.

Two age categories are used in the analysis. Because of the way the SIE questionnnaire was structured, persons 65 and over were not asked some key questions. In these cases, persons 55-64 constitute the unit of analysis. In other questions those 65 and over were included among the respondents. In cases where the response patterns of the two age groups are similar, they are considered together to increase the number of respondents.

Functional disability was measured by responses to five questions ranging from "Does...have a condition which limits the kind or amount of work he/she can do?" to "Does...need help with eating, dressing, or with personal hygiene?" The questions represent a decreasing ability to care for oneself on a daily basis, and any differences that are found between nativity groups will have implications for the long-term care provisions that must be made for them.

The medical resources discussed below are of two types. The first is health insurance. Respondents answered questions on whether or not they possessed an employer group policy, an individual health-care policy, Medicare, or Medicaid. The second type of medical resource discussed is medical services. Respondents were asked if they had received benefits or services from one or more of the following: Medicaid, a neighborhood health center, a low cost clinic, or other public source. Service use was considered to be a partial indicator of access.

Findings

Functional Disability. Because only persons under the age of 65 were asked questions about work, the respondents represented in Table 1 and 2 were limited to those older people most likely to be in the labor force, those 55 to 64. It is evident that the majority of people in all categories enjoy what they perceive to be the capacity to work without serious limitations. There are, however, interesting differences among groups.

A comparison of Mexican nativity groups indicates that the foreign-born are less likely than the U.S.-born to report conditions serious enough to limit their work although this difference is only moderately significant ($X^2=1.29$ $p < .3$). This is nevertheless not the pattern one would expect if the foreign-born tend to be in poorer health than those who have always lived in the U.S. However, because these data do not include any clinical measures of health, we cannot determine whether this pattern indicates similar degrees of physical robustness or greater economic necessity among the foreign-born.

It does suggest that the older foreign-born Mexican American is not necessarily in need of special care.

The pattern shown in the left-hand column of Table 1 is, however, consistent with previous findings that minority elderly are more likely to suffer functional impairment than non-Hispanic white elderly. While there is virtually no difference between U.S.-born blacks and Mexicans, there is a significant difference between Anglos and non-Anglo minorities ($X^2=5.53$ $P < .025$).

TABLE 1

"DOES ... HAVE A CONDITION WHICH LIMITS THE KIND OR AMOUNT OF WORK ... CAN DO?" AGES 55-64

	Percent Answering "Yes" Nativity			
	U.S.	(N)	Foreign	(N)
Anglo	25.6	(799)	–	
Mexican	30.3	(234)	23.9	(88)
Black	30.9	(650)	–	

Anglo-non-Anglo comparison = $x^2 = 5.53$ ldf $p < .025$

Mexican-black comparison = x^2 .029 ldf n.s.

U.S.-born – foreign-born comparison = $x^2 = 1.29$ ldf $p < .3$

TABLE 2

"DOES THE CONDITION KEEP ... FROM WORKING AT ALL?"

	Percent Answering "Yes" Nativity			
	U.S.	(N)	Foreign	(N)
Anglo	65.6	(303)		
Mexican	73.5	(50)	76.2	(16)
Black	77.0	(486)		

Anglo-non-Anglo comparison = $x^2 = 11.94$ ldf $p < .001$

Mexican-black comparison = x^2 2.70 ldf $p < .1$

U.S.-born – foreign-born comparison = $x^2 = .046$ ldf n.s.

Further evidence for greater impairment among minorities is shown in Table 2 where it can be seen that Anglos are the least impaired and blacks the most. The responses shown in this Table represent only individuals 55-64 years of age who admitted to some limitation on work in the previous question. The majority of respondents whose physical conditions were serious enough to put some limits on work, reported that these conditions were also serious enough to stop work completely. For Mexicans, differences in responses of the U.S. and the foreign-born both decreased and reversed. A somewhat larger percentage of foreign-born than of U.S.-born Mexicans reported that their conditions prevented their working at all, although the difference is not statistically significant. A firm conclusion is prevented by the small number of respondents (N=16).

These findings cannot be clearly interpreted as indicating more severe functional impairment among minorities. Because the two questions asked respondents to tell the interviewer about the effects of physical conditions on work, the kind of work done was an important factor in responses. The possibility of continuing in white-collar positions is better than the possibility of continuing in blue-collar positions because of the greater physical demands in the latter. Both Mexicans and blacks are more likely than non-Hispanic whites to be in blue-collar positions (Davis, *et al.*, 1983) and therefore to find themselves hampered in their work by physical conditions which would not stand in the way of white-collar workers. By themselves, these data could simply be indicating the effect of social class rather than physical functioning.

If physical limitations are serious enough, however, they can have an impact on the ability to lead an independent life. The SIE asked three questions about the extent to which the individual required help with some kind of daily activity. Table 3 presents the percentages of persons 55 and over in each ethnic-nativity category for whom a specific kind of help was needed.

It can be seen that for all groups, the percentage of persons requiring a specific kind of help declined as the help became more personal in nature. As was the case in Tables 1 and 2, non-Hispanic whites least often reported a need for any kind of help because of limiting physical conditions. Anglo-non-Anglo differences were most dramatic for help needed around the house ($X^2=77.58$, $P < .001$) and help needed with personal care ($X^2=2.79$, $p < .1$). Very similar percentages of blacks and Mexican Americans reported needing help.

There are small differences in the responses of Mexican Americans by nativity. These differences do not have a consistent pattern, however. A smaller proportion of foreign-born elderly than the U.S. born reported being less able to work around the house ($X2=3.14\, p<.1$). A somewhat larger proportion reported needing help with personal care, but differences did not attain significance. This suggests the same general finding in Tables 1

TABLE 3

PERCENT ANSWERING "YES" TO

	DOES ... CONDITION LIMIT ABILITY TO WORK AROUND THE HOUSE				DOES ... NEED HELP GETTING AROUND OUTSIDE THE HOUSE				DOES ... NEED HELP WITH PERSONAL CARE			
	Nativity											
	U.S.	(N)	Foreign	(N)	U.S.	(N)	Foreign	(N)	U.S.	(N)	Foreign	(N)
Anglo	38.5	(1828)	–		21.8	(396)	–		14.0	(255)	–	
Mexican	55.6	(140)	43.6	(89)	23.6	(33)	21.4	(19)	16.4	(23)	21.4	(19)
Black	52.6	(1862)	–		24.9	(458)	–		20.0	(367)	–	

Anglo-non-Anglo comparison = col. 1 $x^2 = 77.58$ ldf $p < .001$
col. 3 $x^2 = 1.10$ ldf $p < .5$
col. 5 $x^2 = 2.79$ ldf $p < .1$

Mexican-black comparison = col. 1 $x^2 = .76$ ldf $p < .5$
col. 3 $x^2 = .04$ ldf n.s.
col. 5 $x^2 = .98$ ldf $p < .5$

U.S.-born-Foreign-born = cols. 1 & 2: $x^2 = 3.14$ ldf $p < .1$
cols. 3 & 4: $x^2 = .03$ ldf n.s.
cols. 5 & 6: $x^2 = .17$ ldf n.s.

and 2: the foreign-born elderly are less likely to report a limiting condition, but when such conditions exist, they may be more limiting than those of the U.S.-born. However, this tendency needs to be the focus of future research.

Medical Resources. The successful management of physical conditions which result in limitations in important activities may require medical intervention, and old age is generally associated with greater use of medical services. Access to medical services is fundamentally a question of economic resources, either in the form of personal income or third-party payments such as Medicare and Medicaid. It is known that Hispanic minorities have both lower incomes and lower enrollment rates in various kinds of public programs than the general population. While it seems reasonable that the foreign-born elderly would fare even less well, this has never been documented.

Table 4 shows the percentages of persons 55 and over who reported having specific kinds of health insurance or health coverage via Medicare or Medicaid. It is not surprising that non-Hispanic whites are significantly more likely than other groups to have every kind of health insurance except Medicaid. This exception is, of course, an indicator of their relatively superior economic position. Their lesser representation in blue-collar occupations, and much smaller proportions in poverty contribute to their lower participation in Medicaid. In contrast, the proportion of Anglos who have private health insurance is almost twice that of other groups.

There are no consistent patterns of differences between blacks and Mexican Americans. Mexicans are only slightly more likely than blacks to have health coverage through an employer ($X^2=1.68$ $p<.25$). The lack of employer coverage reflects the realities of irregular employment and work in occupations and industries with fewer employee benefits. There is less difference by nativity in individual plan coverage. The relative lack of individual health insurance policies for all three minority categories is in part an indicator of the generally lower income level of these groups. Mexicans also lack the minority-owned companies which have allowed more blacks to purchase such coverage.

Given the heavy reliance of older minority-group members on Medicare and Medicaid for help with medical expenses, it is differences in these kinds of coverage which interest us the most. Differences in Medicaid coverage for the three U.S.-born groups are significant at the .01 level (overall $X^2=7.72$ 2df). What stands out in Table 4 is the high percentage of foreign-born Mexicans who reported being covered by Medicare. The extent of their coverage exceeds that of Anglos, blacks, and U.S.-born Mexicans alike, and this nativity difference is significant ($X^2=4.90$ $p<.05$).

This is not a sign that the foreign-born benefit is out of proportion to need, however. The prime contributor to this nativity-linked pattern is the larger proportion of foreign-born Mexicans, aged 55-65, who report that they received Medicare. Eligibility for Social Security at ages 55 to 64 (and

TABLE 4

PERCENT HAVING SPECIFIC KINDS OF HEALTH INSURANCE

	Employer Group			Individual Plan			Medicare			Medicaid		
	U.S.	(N)	Foreign	(N)	U.S.	(N)	Foreign	(N)	U.S.	(N)	Foreign	(N)	U.S.	(N)	Foreign	(N)
Anglo	41.7	(2826)	—		41.9	(2831)	—		35.1	(1391)	—		6.7	(266)	—	
Mexican	38.8	(127)	22.0	(48)	22.0	(71)	15.7	(34)	31.6	(72)	50.4	(62)	21.1	(48)	29.2	(35)
Black	31.9	(1376)	—		25.1	(1076)	—		40.1	(1147)	—		22.0	(625)	—	
Anglo-non-Anglo: $x^2 = 31.48$ 1df $p < .001$					Ang.-nonAng.: $x^2 = 101.0$ 1df $p < .001$				Ang.-nonAng: $x^2 = 6.97$ 1df $p < .01$				Ang.-nonAng.: $x^2 = 30.2$ 1df $p < .001$			
Mexican-black: $x^2 = 1.68$ 1df $p < .25$					Mex-black: $x^2 = .19$ 1df n.s.				Mex-black: $x^2 = 2.09$ 1df $p < .10$				Mex-black: $x^2 = .021$ 1df n.s.			
U.S.-Foreign-born: $x^2 = 4.36$ 1df $p < .05$					U.S.-Foreign: $x^2 = .57$ 1df n.s.				U.S.-Foreign: $x^2 = 4.90$ 1df $p < .05$				U.S.-Foreign: $x^2 = .73$ 1df $p < .5$			

TABLE 5

PERCENT RECEIVING SELECTED BENEFITS OR SERVICES IN THE LAST 12 MONTHS

	Medicaid			Neighborhood Health Center			Low Cost Clinic			Other Public Source		
	U.S.	(N)	Foreign	U.S.	(N)	Foreign	U.S.	(N)	Foreign	U.S.	(N)	Foreign	(N)
Anglo	5.4	(225)	—	.55	(23)	—	1.0	(47)	—	1.3	(56)	—	
Mexican	15.2	(46)	17.9 (28)	3.0	(9)	1.9* (3)	5.0	(15)	5.1 (8)	2.3	(7)	.64* (1)	
Black	16.9	(563)	—	3.6	(120)	—	6.9	(229)	—	3.4	(114)	—	
Anglo-non-Anglo: $x^2 = 17.85$ 1df $p < .001$				Ang.-nonAng.: $x^2 = .56$ 1df n.s.			Ang.-nonAng: $x^2 = 2.44$ 1df $p < .25$			Ang.-nonAng.: $x^2 = .85$ 1df $p < .50$			
Mexican-black: $x^2 = .34$ 1df n.s.				Mex-black: $x^2 = .078$ 1df n.s.			Mex-black: $x^2 = 2.41$ 1df $p < .25$			Mex-black: $x^2 = .021$ 1df n.s.			
U.S.-Foreign-born: $x^2 = .09$ 1df				U.S.-Foreign: too small to calculate			U.S.-Foreign: too small to calculate			U.S.-Foreign: too small to calculate			

therefore Medicare) is achieved via disability. Thus, the pattern seen in Table 4 probably reflects higher levels of serious disability among these foreign-born Hispanics than among U.S.-born subsamples.

This explanation is consistent with our finding that when foreign-born elderly report a limitation in activity, a larger proportion of them report the inability to work and the need for help with personal care. Of course, whether or not the extent of coverage indicated in Table 4 adequately meets the needs of this group is an important question that cannot be answered with these data.

The different proportions reporting Medicaid coverage (Table 4) do not fully reflect the different income statuses of the subsamples. In the year that the SIE Survey was conducted (1976) approximately 23 percent of Hispanic families fell below the poverty level. In the same year, almost 28 percent of black families were considered to be at or below the poverty level (Davis, *et al.*, 1983:37). There were even larger differences among the elderly. In 1977, the proportions of white, black and Hispanic elderly in poverty were 11.9, 36.3, and 21.9, respectively (Jackson, 1980:144). In spite of these differences, almost identical percentages of Mexicans and blacks reported Medicaid coverage. This may be a function of the former's concentration in urban areas (Davis, *et al.*, 1983).

Information in Table 5 is a partial indication of differences in service use. The data indicate that older Hispanics of Mexican origin use the four types of low-income health service shown here to a lesser extent than blacks although only one of the differences achieves statistical significance. Given the higher poverty rate among elderly blacks (Allan and Brotman, 1981:57), this difference is not surprising. Still, it is discouraging to note how little these services are used.

A comparison of U.S. and foreign-born Mexicans suggests that in spite of generally low use rates, the foreign-born are not less willing or able to utilize these low-cost medical services than their U.S.-born counterparts. The two categories which do show lower use rates among the foreign-born are based on numbers too small to be reliable estimates of use.

CONCLUSIONS

The expected pattern was based on the assumption that lower income and occupational status among the foreign-born take their toll in more severe physical ailments and more physical dependency. The data suggest that when older foreign-born Hispanics of Mexican origin experience limitations on physical activity, the problems are somewhat more likely to produce dependency-both economic and physical-than is the case with their U.S.-born counterparts. However, nativity differences were smaller than expected, and further research is needed to clarify the relationship between nativity and physical dependency.

If greater dependency among the foreign-born can be demonstrated, there are immediate implications for both Hispanic families and formal support systems. If Mexican American families are changing toward an emphasis on the nuclear family (*e.g.*, Kalish, 1977:40), then networks of help and support for highly dependent immigrant parents will also change in form. While families are expected to continue to be the primary supports of their elderly members, changes in how this is done can be expected to produce strain.

The foreign-born Mexican elderly also appear to be highly dependent on Medicare as a way of meeting medical expenses. In spite of recent attempts to make Medicare more responsive to noninstitutional care needs, it remains a system geared primarily to acute care. Our data indicate that the limitations reported by our sample of Mexican Americans are caused primarily by chronic conditions which typically do not require frequent attention from medical professionals.

For example, the SIE indicates that among 67 percent of the Mexicans reporting some degree of limitation in activity, the limitation was produced by hearing or vision problems, by arthritis or by back trouble. If their problems with these ailments are more severe, as our data suggest they may be, the immigrant elderly should be particular targets for service such as home health care.

Our finding that their use of low-income medical services is comparable to that of their U.S.-born age peers also leads us to speculate that the language barrier may not be as much of an obstacle to service use as thought by some. As Guttman (1980:15) suggests, the importance of language barriers in applying for and receiving benefits may be less important than problems with eligibility and the procedures that are required in applying for public health benefits. These levels of service use, coupled with information that Hispanics prefer to use private physicians for their medical needs (Valle, 1983; Welch, *et al.*, 1973), also suggest that the effort to improve health-care services to Hispanics should be extended to include ways to facilitate access to private physicians.

The data presented here indicate that nativity status is a variable that cannot be ignored in future assessments of Hispanic health issues. They also indicate, however, that our assumptions regarding the impact of nativity on functioning and service use need to be reassessed. Given the continuing prominence of immigration in the growth of Hispanic subgroups, the immigrant-grown-old will be a consideration of policy makers and program designers for years to come.

REFERENCES

Allan, C. and H. Brotman
1981 *Chartbook on Aging in America*. Washington, DC: The White House Conference on Aging.

Andersen, R.
1968 *A Behavioral Model of Families' Use of Health Services*. Chicago, IL: Center for Health Administration Studies.

Associacion Nacional Pro Personas Mayores
1980 *A National Study to Access the Service Needs of the Hispanic Elderly*. Los Angeles, CA: Associacion Nacional Pro Personas Mayores.

Bailey, D.J.
1983 "Health of Hispanics". In *The Hispanic Population of the United States*. Washington, DC: U.S. House of Representatives. Pp. 89-106.

Bean, F.D. and W.P. Frisbie
1978 *The Demography of Racial and Ethnic Groups*. New York: Academic Press.

Bell, D, P. Kasschau and G. Fellman
1976 *Delivering Services to Elderly Members of Minority Groups: A Critical Review of the Literature*. Santa Monica, CA: The Rand Corporation.

Bullough, V.L. and B. Bullough
1982 *Health Care for the Other Americans*. New York: Appleton-Century-Crofts.

Cantor, M.
1979 "Effect of Ethnicity on Life Styles of the Inner-City Elderly". In *Dimensions of Aging: Readings*. Edited by J. Hendricks and C.D. Hendricks. Cambridge: Winthrop Publishers.

Cervantes, R.A.
1972 "Urban Chicanos, Failure of Comprehensive Health Services", *Health Services Reports*. 87:932-940. December.

Chavez, L.R., W.A. Cornelius and O.W. Jones
1985 "Mexican Immigrants and the Utilization of U.S. Health Services: The Case of San Diego", *Social Sciences and Medicine*. 21:93-102.

Davis, C., C. Haub and J. Willette
1983 "U.S. Hispanics: Changing the Face of America", *Population Bulletin*. Vol. 38.

Guttmann, D.
1980 *Perspective on Equitable Share in Public Benefits by Minority Elderly*. Executive Summary. Washington, DC: The Catholic University.

Jackson, J.J.
1980 *Minorities and Aging*. Belmont, CA: Wadsworth Publishing Company.

Kalish, R.A.
1977 *The Later Years, Social Applications of Gerontology*. Monterey, CA: Brooks/Cole Publishing.

Keefe, S.E.
1982 "Help-seeking Behavior Among Foreign-born and Native-born Mexican Americans", *Social Science and Medicine*. 16:1467-1474.

Keefe, S., A.M. Padilla and M.L. Carlos
1979 "The Mexican American Extended Family as an Emotional Support System", *Human Organization*. 38:144-152. Spring.

Mechanic, D.
1972 "Sociology and Public Health: Perspective for Application", *American Journal of Public Health*. 62:146-151.

Montiero, L.A.
1973 "Expense is no Object: Income and Physicians Visits Considered", *Journal of Health and Social Behavior*. 14:99-115.

Morrison, B.J.
1983 "Physical Health and the Minority Aged". In *Aging in Minority Groups.* Edited by R.L. McNeely and J.L. Colen. Beverly Hills, CA: Sage Publications. Pp. 161-173.

National Center for Health Statistics
1984 *Health, Indicators for Hispanic, Black, and White Americans. Data from the National Health Survey.* Series 10, No. 148. Washington, DC: DHHS.

Office of Management and Budget
1983 *The Budget of the Federal Government, 1983.* Washington, DC: U.S. Government Printing Office.

Padilla, A. and S. Keefe
1984 "The Search for Help: Mental Health Resources for Mexican Americans and Anglo Americans in a Plural Society". In *The Pluralistic Society: A Community Mental Health Perspective.* Edited by S. Sue and T. Moore. New York: Human Sciences Press.

Rabin, D.C., T.W. Bice and B. Starfield
1974 "Use of Health Services by Baltimore Medicaid Recipients", *Medical Care.* 12:561-570.

Roberts, R.E. and C. Askew
1972 "A Consideration of Mortality in Three Subcultures". Health Services Report. 87:262-270.

Russell, L.B.
1981 "An Aging Population and the Use of Medical Care", *Medical Care.* 19(6):633-643.

Schur, C.L., A.B. Bernstein and M.L. Berk
1986 "The Importance of Distinguishing Hispanic Subpopulations in the Use of Medical Care". Paper read at the 1986 Annual Meetings of the American Sociological Association, New York.

Stanford, E.P.
1977 *Comprehensive Service Delivery Systems for the Minority Aged.* San Diego, CA: Campanile Press.

Torres-Gil, F. and M. Negm
1980 "Policy Issues Concerning the Hispanic Elderly", *Aging.* 305-306:2-5.

Vallbona, C.
1984 "Problems in Providing Adequate Health Care to Hispanic Populations". In *Hispanic Mosaic: A Public Health Services Perspective.* Edited by M. Sotomayor. Washington, D.C. Pp. 8-30.

Valle, R.
1983 "The Demography of Mexican American Aging". In *Aging in Minority Groups.* Edited by R.L. McNeely and J.L. Colen. Beverly Hills, CA: Sage Publications. Pp. 66-71.

U.S. Bureau of the Census
1984 *Statistical Abstract of the United States, 1984.* Washington, DC: U.S. Government Printing Office.

Walker, G.M.
1979 "Utilization of Health Care: The Laredo Migrant Experience", *American Journal of Public Health.* 69:667-672.

Welch, S., J. Comer and M. Steinman
1973 "Some Social and Attitudinal Correlates of Health Care Among Mexican Americans", *Journal of Health and Social Behavior.* 14:205-213. September.

Wolinsky, F.D., R.M. Coe, D.K. Miller, J.M. Pendergast, M.J. Creel and M.N. Chavez
1983 "Health Services Utilization Among the Noninstitutionalized Elderly", *Journal of Health and Social Behavior.* 24(4):325-337.

Young, C.L.
1979 "Providing Health and Social Sciences to Illegal Alien Families: A Dilemma for Community Agencies", *Social Work and Health Care.* 4:309-318.