Race and ethnicity, nativity, and issues of health care

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Abstract:

"Age and Health in a Multiethnic Society: Health Care Issues" highlights two very important social facts of the early twenty-first century. U.S. immigration is at new highs, paralleling the influx of persons at the beginning of the century and contributing to greater heterogeneity. The second social fact is the ever-increasing emphasis on health, health care, and health policy as expressed in political campaigns and in President Bill Clinton's call for Healthy People 2010.

Keywords: race and ethnicity | elder care | health care satisfaction

Article:

"Age and Health in a Multiethnic Society: Health Care Issues" highlights two very important social facts of the early twenty-first century. U.S. immigration is at new highs, paralleling the influx of persons at the beginning of the century and contributing to greater heterogeneity. The second social fact is the ever-increasing emphasis on health, health care, and health policy as expressed in political campaigns and in President Bill Clinton's call for Healthy People 2010.

While it is well-known that America's elderly population is growing ethnically diverse, in-migration as an appreciable contribution to growing ethnic diversity is less often pointed out. The end of the twentieth century saw the numbers migrating to this country approximate the level of the first decade of the century: 7,338,000 in the 1980s compared with 8,795,000 in 1900-10 (Table 1). However, the larger population base at the end of the century makes the proportion of immigrants smaller now than at the beginning of the century. After the changes in the immigration laws of the 1960s, much in-migration to the United States has been from non-European countries composed of both work and family reunification streams. Thirty years later, the impact of this increasingly diverse in-migration can be seen in the changing composition of American elders, especially in terms of both ethnicity and nativity (Table 2). The proportion of White non-Hispanic persons among those aged 65 and older declined between 1990 and 1999, while that of every other ethnic group increased (column 3 vs. column 6). Strikingly, we see that the proportion of foreign-born among elderly persons has increased for every ethnic group except non-Hispanic Whites (percentages shown in columns 1 and 2 vs. 4 and 5). For Asian and Pacific Islanders, the foreign-born substantially outnumber the native-born increasingly over the decade. For those of Hispanic ethnicity too, the proportion of foreign-born almost equals that of

those who were born within the United States. Although these Census figures do not tell us the ages at which the foreign-born immigrated and thus the length of time they participated in the U.S. work and benefits system, it appears increasingly evident that issues of ethnicity and nativity will be relevant for researchers and planners concerned with reducing health disparities among elderly persons in the United States.

Table 1. Immigration and Emigration by Decade: 1901-90 (numbers in thousands)

Period	Immigrants to the United States	Emigrants to the United States	Net Immigration	Ratio: Emigration/ Immigration
Total, 1901–90	37,869	11,882	25,987	0.31
1981–90	7,338	1,600	5,738	0.22
1971–80	4,493	1,176	3,317	0.26
1961–70	3,322	900	2,422	0.27
1951–60	2,515	425	2,090	0.17
1941–50	1,035	281	754	0.27
1931–40	528	649	–121	1.23
1921–30	4,107	1,685	2,422	0.41
1911–20	5,736	2,157	3,579	0.38
1901–10	8,795	3,008	5,787	0.34

SOURCE: U.S. Department of Justice, Immigration and Naturalization Service, 1999.

Table 2. Population Aged 65+ by Ethnicity and Nativity, 1990-99 (numbers in thousands, percentage of total in parentheses)

	1990			1999		
	Foreign-Born	Native-Born	Total	Foreign-Born	Native-Born	Total
Total	2,733.00 (8.79)	28,351.00 (91.21)	31,084.00	3,206.00 (9.28)	31,334.00 (90.72)	34,540.00
White non-Hispanic	1,784.40 (6.60)	25,259.90 (93.40)	27,044.95 (87.01)	1,575.60 (5.45)	27,349.50 (94.55)	28,925.59 (83.75)
African-American non-Hispanic	73.7 (3.01)	2,376.30 (96.99)	2,450.03 (7.88)	123.30 (4.47)	2,635.40 (95.53)	2,758.74 (7.99)
American Indian, Eskimo, Aleut, non-Hispanic	2.2 (2.03)	106.4 (97.97)	108.60 (0.35)	4.7 (3.28)	138.5 (96.72)	143.20 (0.41)
Asian and Pacific Islander non-Hispanic	306.3 (69.60)	133.7 (30.04)	440.11 (1.42)	600.1 (78.10)	168.1 (21.90)	768.39 (2.22)
Hispanic	565.5 (48.69)	595.9 (51.31)	1,161.71 (3.74)	891.2 (49.30)	916.3 (50.70)	1,807.78 (5.23)

SOURCE: U.S. Census Bureau, Population Division (2000).
NOTE: These figures are estimations and projections based on the 1990 Census. The 2000 Census figures were not yet available at the time of writing.

At the same time, President Clinton in his radio address of February 21, 1998, committed the nation to two ambitious goals: one, to increase the quality and years of healthy life, and two, eliminate health disparities among different segments of the population. The evidence that links race and ethnicity to health disparities is very compelling and emphasizes the burden of illness and death experienced by African Americans, Hispanics, American Indians and Alaska Natives, and Pacific Islanders compared with the U.S. population as a whole. The American Medical Association (AMA) (1999) calls attention to these disparities in access to and satisfaction with health care. The AMA reports that 29% of minorities in comparison to 16% of Whites say they have little or no choice about where to get health care; 21% of minority adults have problems with language differences in receiving care, with about one-fourth of those who do not speak

English as a first language needing an interpreter when seeking health care services; 60% of Whites in contrast to 46% of minorities say they are satisfied with their health care; and 15% of adults in all minority groups believe their medical care would be better if they were a different race.

At the same time, the AMA reports from the Physician Payment Review Commission (PPRC) on Monitoring Access of Medicare Beneficiaries that African American beneficiaries continue to have access problems, which is reflected in their use of emergency rooms more than other beneficiaries, further suggesting the lack of a customary physician. The PPRC analysis was especially concerned about the older population, as Medicare reduces the primary barrier of financial limitations. On the more positive side, however, the AMA sees encouragement in studies that report (1) neighborhood clinics and hospital outpatient departments are offering care to minority groups "comparable" to services provided by private physicians, (2) minority groups receiving regular care from such facilities report access comparable to patients with private physicians, and (3) providers who are similar to their patients in race or ethnicity are filling a critical void for minority patients.

These reports suggest that attention needs to be paid to differences in ethnicity and immigrant status in considering access to health care and quality of and satisfaction with the care received. The articles included in this issue illustrate aspects of these interrelationships.

The article by Kuo and Torres-Gil on factors affecting utilization of health services and home- and community-based care programs by older Taiwanese in the United States illustrates the need for studies examining the interaction of specific ethnic/cultural subgroups, particularly those who are recent immigrants, with the U.S. health care system. Such studies raise the question of whether the health care system serving seniors can meet the challenges of growing ethnic diversity by providing specific services for diverse linguistic or national subgroups, or by considering the special needs of immigrants in contrast with older-established minorities, or by some combination of the two. Such studies demonstrate that the broad-based publicly funded or organized health system for seniors needs to interact closely with community-based organizations that are most familiar with the intricate cultural details of each group.

Specifically, Kuo and Torres-Gil examine which factors influence use of health care services and home and community-based services by elderly Taiwanese residents of California. Most of these residents immigrated after retirement. They find that the Andersen behavioral model of health service use (Andersen 1995; Andersen et al. 1995) in its most recent form is applicable in studying immigrant ethnic minority groups. Kuo and Torres-Gil find that use of nondiscretionary services (hospital stay) is mainly related to structural enabling and need factors such as acute health conditions, living alone, ability to speak English, and increasing years since immigration. The use of discretionary services such as doctor visits are related to predisposing cultural factors, including children living in the region, using alternative medicine, and preferring providers of a similar cultural background. Similarly, use of home- or community-based services is also influenced by these cultural factors, as well as having functional limitations.

In a similar vein, Baxter, Bryant, Scarbro, and Shetterly examine patterns of rural Hispanic and non-Hispanic Whites' use of health care in the San Luis Valley Health and Aging Study. These

authors also use Andersen's behavioral model (Andersen 1995; Andersen et al. 1995) as a mechanism to inform us of potential differences in access to care and to cultural norms related to need and appropriateness of care. The factors that have generally been found to predispose persons to use of health care include measures of demographic attributes, social structure, and cultural beliefs, while the enabling characteristics include family and community resources related to health care use. The need factors are the perceived and objective health status. On many of these variables, Hispanics differ from the non-Hispanic White population. In general, Hispanics have less education, are more likely to live in poverty, have lower-paying jobs, and are less likely to have health insurance. Without insurance, they are less likely to have a regular provider or to have annual visits to the physician. Yet, given all of this, their review of health care use shows a great deal of inconsistency. Perhaps part of the reason is that the Hispanic population itself is ethnically diverse with Mexican Americans, Puerto Rican Americans, Cuban Americans, and "other Hispanics."

The study by Baxter et al. focuses on Mexican Americans and "other Spanish/Hispanic" persons who live in the rural area of the San Luis Valley of southern Colorado. Their study replicates findings reported by the AMA that minority groups who receive regular care from neighborhood clinics and hospital outpatient departments report access comparable to patients with private physicians. The residents of the San Luis Valley have access to a community health center, and Baxter et al. find that the rates of outpatient visits, hospitalization, and having a regular source of care do not vary significantly by ethnicity. In this particular location, language is also not a barrier, and the authors note that the San Luis Valley has a relatively stable population with little recent immigration from Mexico. The authors comment on the quality of the community health clinic that provides services to the entire valley at no or reduced cost. In addition, the provider and staff have experience and competence with the diverse population they serve. Interviewers for the study were all bilingual.

The primary differences in utilization revolve around the use of nursing homes and professional home-nursing services. A significantly smaller proportion of the Hispanic population was living in nursing homes at the time of the study, but Hispanics use more professional home-nursing services. More professional nursing services vary by acculturation levels with larger percentages of people with low or medium acculturation levels using these services, but this relationship disappears after controlling for education. Differences in nursing home use persist after all controls for enabling and need factors are included in the model.

Caring for elderly persons, whether in their own homes or the homes of family members, is more customary in many ethnic and minority groups in comparison to the majority White population. This may rest on a value system, or it may be a response to perceived barriers to access or to the financial costs of nursing homes and other types of facilities that provide personal care to elders who are unable to live independently, such as rest homes, board and care homes, or adult care homes.

This is the topic of the article by Mutran, Sudha, Desai, and Long. They examine the issue of satisfaction with care in facilities that are called "adult care homes" in the state of North Carolina. These are the facilities that are more colloquially called "rest homes" by the general population. Many of these homes serve persons who are predominantly members of one

racial/ethnic group or the other. While the authors do not look at the effect on satisfaction with care due to similarity between the care providers and the care recipients—the subject of the article by Berdes and Eckert—they do examine the differences in satisfaction based on the percentage of African Americans in the home, which captures whether the person is living with others of the same race. The authors find that African Americans are less satisfied with their care and that the variables that explain their satisfaction, or lack thereof, are different than the variables that contribute to White satisfaction. The finding that Whites in contrast to minorities are satisfied with their health care, as reported in the AMA (1995) document, can be extended to facilities that provide personal care and service.

The authors identify three dimensions of satisfaction. First, there is the satisfaction that results from a sense of familiarity, a sense of being "at home." Second, there is an expression of satisfaction with staff and the care they deliver. And third, there is an overall assessment of satisfaction with the facility. This study of adult care homes finds that African Americans have a greater feeling of being at home in residences that house six or fewer people and when the older individual takes part in the decision to enter a home. They are also more satisfied with being in a facility when they have more need of physical assistance, leading to the suggestion that perhaps African Americans more than Whites use "need" to rationalize the decision to enter such a home. The research also shows that African Americans have difficulty adjusting to the facility the more recent the move. Whites, on the other hand, feel more at home when frequency of family contact increases. And White women are more satisfied than White men are.

Similar variables explain African Americans' satisfaction with the staff, with one exception. This group is more satisfied when there are fewer private rooms. The authors interpreted this as an indication of the social climate of the home. More private rooms may reflect a greater number of higher-paying clientele who are likely to be accommodated first. For Whites, satisfaction with the staff is greater among women than among men. One variable does affect the satisfaction levels of both African Americans and Whites: their satisfaction with their own health. This variable is added to control for a tendency of persons to say, "All is well," when in truth it is not. Second, it may be that those who are satisfied with their health find it easier to be satisfied in other areas.

In looking at the pattern of results, it appears that African Americans are dealing with a new phenomenon. They prefer facilities that are smaller, take more time to adjust, want to be in on the decision-making, and enter a home with fewer private rooms and with lower changeover in the staff. Their overall satisfaction is linked to satisfaction with the "like home" and staff qualities. On the other hand, the satisfaction of Whites is predicted by fewer variables. Gender (women), age (being older), frequency of family contact, and being dependent affects one or the other measures of satisfaction. Only satisfaction with staff is related to the overall satisfaction of Whites.

The next article in this issue is written by Howard, Konrad, Stevens, and Porter and examines the racial matching of physician and patient in effectiveness of care, use of services, and patient satisfaction. They address one of the findings mentioned earlier in the report of the AMA (1995) that providers who are similar to their patients in race or ethnicity fill a critical void for minority patients. The authors of this article present two alternative views of why physicians' ethnicity

and patients' health might be linked. One is the belief, based on historical patterns of geographic distribution and service provision, that increased numbers of African American physicians will increase the availability of physicians to African American communities, increasing access and improving outcomes. The alternative belief asserts more subtly that African American patients require ethnically similar physicians to receive optimal medical care, that is, African American physicians will understand the cultural and social context of illness in this community and thus more effectively communicate with the patient.

Howard et al. fill a gap in the existing literature by examining a sample of elderly African Americans and Whites who have identified an African American or a White physician as their usual health care provider. They are also able to examine the relationship between the social and clinical characteristics of the survey respondents along with the characteristics of their usual care physicians. The authors look at several dependent variables: the elders' pattern of care for hypertension, whether the respondent delayed seeking care quite often, emergency department visits as a proportion of total visits, and elders' satisfaction with care. Their study population is drawn from the Piedmont Health Survey of the Elderly (PHSE) conducted by the Duke University Center for Aging and Human Development as part of the Established Populations for Epidemiologic Studies of the Elderly (EPESE).

Their work shows the importance of considering the setting in which the physicians works and the predominance in the number of White physicians versus African American physicians. The PHSE has only 34 physicians who are African American, 31 of whom serve 720 African American elders, while 3 serve 36 White elders. Of 243 White physicians, 87 serve 696 African American elders, while 156 serve 1,415 White elders. The African American and White physicians are statistically similar in gender, age, and years since graduating from medical school. But African American physicians are less likely to be board certified than White physicians are and more likely to work in primary care and in community health centers.

Howard and his colleagues find that race of the elder is related to being told about high blood pressure, being given blood pressure medication, and taking the medication but also putting off care quite often. African Americans are known to have higher rates of hypertension, more severe conditions, and a worse prognosis for cardiovascular morbidity and mortality. The authors speculate that physicians may be more sensitive to these patterns and their deadliness to African American elders. African American physicians appear to be more effective in securing elders' compliance with taking their medications than White physicians.

Perhaps the most perplexing finding of this study, though, is the relationship of satisfaction with care and the dyad of racially similar physician and patient. African American elders with African American physicians are less satisfied than other types of dyads. The authors offer several explanations for this finding, which include history and experience in a "separate, but unequal" medical care system in which African American physicians might be inadvertently associated with inferior quality. On the other hand, African American physicians might also be delivering care in settings where constraints from scarce resources affect the quality of care. Thus, paradoxically, clinics that may be in the local community and serving primarily people associated with these communities, and have culturally competent staff, are likely to have fewer

resources. So on one hand, there are positives about help from a community source, as in the article by Baxter et al., but negative effects if the resources are stretched too thin.

The contribution by Berdes and Eckert provides an important reminder of how the social facts of ethnicity and nativity influence quality of care, not only from the perspective of consumers' interaction with the upper-level providers such as doctors, nurses, home administrators, and so forth but also from the rank-and-file staff such as nurse's aides, who carry out the instructions of the health care professionals and provide the daily interaction and personal care for the residents. Studies have long documented the twin facts that many nurse's aides are both foreign-born and from less privileged socioeconomic backgrounds (e.g., Tellis-Nayak and Tellis-Nayak 1989). Nurse's aides tend to be female African Americans or foreign-born and have the least education, skills, pay, and thus the lowest occupational status in health care. The institutional culture of the nursing home reinforces their negative situation, ignoring the aides' affective needs and doing nothing to bolster their self-esteem. The nursing home becomes a menial job in an impersonal setting serving difficult-to-please managers and clientele.

Berdes and Eckert provide new evidence for the ongoing presence and corrosive effects of racism and xenophobia faced by nurse's aides. This study uses qualitative methods to explore the world of interpersonal relations between nursing home residents and the caregiving staff and between the staff themselves. The article focuses on race relations. They find that one-third of the residents exhibit race-related attitudes, which take two forms: anachronistic racism (language not acceptable today but commonly used in the past) and malignant racism (comments intended to be offensive). Nurse's aides discount the former, attributing it to residents' age, social background, lack of education, or mental competence, and use various coping strategies to maintain a caring attitude, or they sometimes successfully reeducate residents to use more acceptable language. Malignant racism, however, could not be coped with by these means. Ethnic minority nurse's aides experience racism from residents and from their coworkers. In particular, immigrant workers face a conflation of racism and xenophobia, where they encounter additional prejudice from native-born ethnic minority coworkers. The authors conclude that racial differences between residents and nurse's aides will continue to be a problem as long as nursing homes are effectively segregated in terms of ethnicity of residential clientele. Their study indicated that more than three-quarters of nurse's aides experience racism on the job, which they describe as a "monumental problem and deserving of urgent attention."

The articles included in this second and final issue of the special edition on age and health in a multiethnic society focus on the ways ethnicity and nativity of clients and service providers interact to influence access to care and quality of care. They provide a representation of the many complex issues that face those who are engaged in crafting policies and plans related to reducing disparities in the health of seniors. On one hand, some of the studies suggest that similar conceptual models underpin the experience of diverse groups' interaction with the health care system (such as the Andersen model of health service use or quality-of-care frameworks). These models serve to highlight the similarities in the way different ethnic groups engage with the health care system, as well as the different specific variables that influence use for each group. They highlight commonalties as well as differences. Community-based organizations, on the other hand, often do well when they customize their services to clients of a specific ethnic or cultural subgroup. For them too, however, periodic communication and cooperation across

groups at different levels serves to improve services and build bridges for their clientele with the overall health care system. These articles represent only the tip of the iceberg; much further research is needed to explore the complex and changing health issues facing ethnic minority seniors in America today.

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