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Structural and Cultural Factors in Successful Aging Among Older Hispanics

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Abstract

Successful or healthful aging are terms that draw attention to life course issues related to individual, physical, and psychologic development and maturation, but they also draw attention to the material basis of successful aging and the social structures that determine one's place in the social hierarchy. This article focuses on barriers to optimal aging for Hispanics, especially those of Mexican origin, and argues that cultural factors and social class are closely associated. The reduction of health disparities and equity in medical and long-term care requires an understanding of both cultural and material sources of differential health levels.

Keywords

culture; health disparities; Mexican-origin; social structure

Currently, people in the developed world are living longer than any previous generation. In 2004, the average life expectancy at birth in the United States was 75.2 and 80.4 years for men and women, respectively.¹ At age 65, the average male could expect to live 17.1 years longer and the average female 20 years longer. Compared to the developing world, even poor Americans enjoy the health advantages of a developed economy and modern medicine. Yet, because of a long history of inequality and differential health risks, racial and ethnic group differentials in illness and death persist.² Life expectancy for African Americans is 5.1 years shorter at birth and 1.5 years shorter at age 65 than for Whites.¹ On the other hand, despite a less favorable socioeconomic profile than non-Hispanic Whites, the Mexican-origin population has similar or even longer life expectancies at birth and at age 65.^{3,4} Despite this favorable mortality profile, older Mexican-origin individuals suffer substantial disability and the health consequences of high rates of chronic diseases such as diabetes.³

This reality of longer life and poorer health in Mexican-origin Americans draws attention to the fact that longevity alone is not the ultimate indicator of successful aging. Increasingly, factors related to the quality of the life are of theoretical and practical interest.⁵ In this article, I define successful aging broadly as a process that results in optimal physical functioning, emotional well-being, and social engagement. This ideal state of emotional fulfillment and social engagement is similar to Maslow's concept of self-actualization in

which the achievement of one's full human potential depends on more than material factors.⁶ For Maslow, as for others, wealth is not the ultimate end in life, nor does it bring satisfaction independent of what one does with it. Yet, money and wealth are hardly irrelevant. In Maslow's theory, self-actualization requires the satisfaction of what he termed "deficiency needs," a concept that refers to the lower-order needs that are part of a hierarchy of life challenges.

Clearly, much of the potential for such an outcome is innate and depends on the temperament and personal characteristics with which one is born, but it also depends on the opportunities and realities of the social, economic, and political environment in which one is born and lives. From this perspective, successful aging depends on both agency and structure. Although some remarkable individuals overcome tremendous obstacles and thrive in adverse conditions, the ability to take advantage of opportunities requires that they be available. As a long history of research in social stratification clearly shows, individuals from different racial and ethnic groups do not enjoy the same opportunities.

MEXICAN-ORIGIN ELDERS

Even as the Mexican-origin population remains relatively young because of high fertility and the immigration of young adults, the number of older Hispanics is also growing rapidly.³ The 2 major objectives of this new research on Hispanics are to (1) identify the cultural and structural factors that account for relatively favorable morbidity and mortality experiences among immigrants^{7,8} and (2) account for the high rates of chronic disease and disability in older Mexican-origin individuals.^{3,9} The complex and puzzling illness and mortality profile of the Mexican-origin population, including high morbidity and low mortality, has been attributed to many factors, including methodologic artifacts.^{10,11} Low mortality accompanied by significant morbidity and functional incapacity are made more puzzling in light of relatively low rates of health insurance coverage among Mexican-origin individuals at all ages. Although they have nearly universal Medicare coverage, older Mexican-origin individuals are less likely than non-Hispanic elders to have private Medigap policies.^{12,13}

In what follows, I discuss the relative importance of cultural and structural factors in determining levels of health and illness in older Mexican-origin individuals. My argument is that analysis of health disparities in older Mexican-origin individuals must be informed by an understanding of the fundamental associations among cultural and structural factors. Certain cultural markers associated with a history of exclusion and social marginality place individuals and groups in structurally vulnerable situations with respect to economic security and healthcare access. Most studies of Mexican-origin health and healthcare use include controls for acculturation or language of interview to tap the most salient aspects of culture and cultural assimilation. Individuals of Mexican origin clearly differ greatly in their level of acculturation and fluency in English. Among older samples, a lack of English proficiency is common and many older individuals have not acculturated to the same degree as younger individuals. Although a focus on culture is clearly important, it is also important to remember that culture and structure interact in complex ways.

SOURCES OF HEALTH DISPARITIES: CULTURE OR SOCIAL STRUCTURE?

Poverty levels and their health consequences in the developed world pale in comparison to the health consequences of the extreme poverty typical of developing nations. However, this does not make inequality less salient, nor does it mean that the health consequences of inequality have been overcome in rich nations. Despite relatively greater access to medical care for all social groups in the United States, serious health disparities based on race and wealth persist.^{2,14–17} Poverty and inadequate healthcare undermine the health of entire communities.^{18,19} A lack of adequate insurance increases the risk of mortality from cancer and other serious diseases, largely as the result of late diagnoses and inadequate treatment.^{20–22}

As noted earlier, despite the generally poor socioeconomic profile of the Mexican-origin population, a large number of studies report a favorable mortality profile in comparison to other racial and ethnic groups at every age.^{7,8,10,23–27} Although this favorable mortality experience may to some degree reflect methodologic problems related to the underestimation of mortality in the Mexican-origin population,¹¹ life expectancy at birth and later in life for Mexican-origin individuals compares favorably to that of non-Hispanic Whites.³ At the same time, though, elderly Mexican-origin individuals suffer relatively high levels of functional impairment and greater morbidity and mortality associated with chronic diseases such as diabetes.^{2,9,28–36}

Tables 1 and 2 are modified from earlier work³ and are based on weighted data from the 1993–1994 Hispanic Established Populations for Epidemiologic Studies of the Elderly (Mexican American EPESE) and the 1990 Duke EPESE, which provides similar information for samples of older non-Hispanic Whites and Blacks. The Mexican American EPESE is one of the most comprehensive studies on the health of older Mexican-origin individuals available. Table 1 presents the percentage of survey respondents with major chronic health conditions by age and race/ethnicity. In many cases, Mexican-origin men and women compare favorably to non-Hispanic Whites and Blacks. Among those aged 65 to 74 years, Mexican Americans have lower hypertension rates, lower proportions of heart attacks, and higher rates of diabetes. Among those aged 75 to 84 years, Mexican Americans have high rates of diabetes and Mexican American women have very high rates of stroke. Among those older than 85 years, Mexican Americans continue to have higher rates of diabetes, but their rates of cancer and stroke are favorable in comparison with those of non-Hispanic Whites.

These data clearly reveal the well-documented high risk of diabetes for Mexican-origin adults. Table 2 presents data on functional impairments, including the percentage of non-Hispanic White, Black, and Mexican American men and women of different ages who have trouble in 3 areas: doing heavy housework, climbing stairs, and walking half a mile. In all 3 areas and for all ages, larger percentages of Mexican American women report difficulties in carrying out the task. After age 75, the proportion of men reporting difficulty climbing stairs and walking half a mile is greater than that of non-Hispanic Whites or Blacks. Table 2 reveals various complex patterns of functional capacity that differ by gender, race, and ethnicity.

Given these high levels of morbidity and functional impairment, high quality and continuous healthcare is clearly necessary, but often not available. Table 3, based on recent data from the Current Population Survey, shows that compared with non-Hispanic Whites and African Americans, Mexican-origin elders are less likely to participate in Medicare and to own a private Medigap policy to cover the substantial potential medical costs that Medicare does not. The persistence of disparities in disease prevalence gives rise to questions about the factors that account for them.

The African American and Latino experiences and their position in the social hierarchy today have been shaped by economic and political forces that have left many members of these groups blocked in terms of the capacity to accumulate material and social capital. The extent to which this blockage relates to culture, or even whether the concept of culture contributes to our understanding of the barriers to economic and social advancement, remains unclear. The concept of culture relates perhaps more logically to the study of Latinos than to African Americans, largely because of the persistent use of Spanish in these groups. However, even in Latinos, it is unclear what a focus on culture means or what relevance it has for understanding health disparities. Cultural differences defined in terms of language use, food preferences, religious practices, and the like abound, yet we focus on only selected group differences. For Hispanics, African Americans, and Native Americans, within-group differences are less relevant in motivating research attention than the collective disadvantage of the group as a whole. In the end, one suspects that culture, at least as it is operationalized in everyday research, serves mainly as a proxy for structured social disadvantage.

Except for specific genetic predispositions, such as that for Tay-Sachs disease, ethnic group membership is in and of itself of little interest or utility in explaining the major health disparities that afflict minority populations. These elevated health risks experienced by minority populations are related to poverty, which in turn reflects historically blocked opportunities and institutional racism.³⁷ Institutional racism and discrimination perpetuate poverty and its health risks because its victims are confined to unhealthful environments, face blocked educational opportunities in poor schools, remain trapped in low-wage occupations, and receive inferior medical care. These multiple disadvantages can have psychologic effects and result in the helplessness and hopelessness typical of depression.³⁸

A large body of research demonstrates that labor market segregation places African Americans and Hispanics at a disadvantage in terms of health insurance and the capacity to optimize health and well-being.³⁹ Historically, African Americans and Hispanics have been disproportionately confined to the low-wage service sector or the informal economy, where their ability to accumulate wealth is seriously impaired. Discriminatory practices in the real estate market have confined many members of these groups to unsafe neighborhoods with few local employment opportunities or community resources and inferior schools.⁴⁰ Such confinement and the chronic poverty from which it stems can result in chronically high levels of physical and social stress that increases the risk of poor health and vitality for entire groups.¹⁸ Poverty, relative deprivation, and the stress experienced early in the lives of poor people combine with their vulnerability to a variety of stressors throughout adulthood to increase their risk of demoralization and depression in late life.^{41,42} Older women with

low incomes are at high risk of social isolation and many experience a series of negative life events that are difficult for them to deal with because of the lack of resources.⁴³

DIFFERENTIAL HEALTHCARE ACCESS

Minority Americans face serious economic barriers to high-quality care.^{12,44–46} In the employment-based system of healthcare coverage that characterizes the United States, a good job is by definition one that not only provides a good salary but also retirement and health benefits. Individuals who find themselves trapped in low-wage service sector jobs not only lack benefits but also they are unlikely able to purchase private healthcare insurance or save for retirement.⁴⁷ For minority Americans, the inability to accumulate assets is often accompanied by other social disadvantages that can undermine healthful aging. Perceived discrimination, which many poor minority Americans suffer, has been shown to increase reports of depressive symptoms.^{38,48} Although Medicare has made healthcare coverage among those older than 65 years nearly universal, perhaps 5% of older Mexican-origin individuals report that they are not enrolled, and a far higher fraction do not own supplemental Medigap plans to cover what Medicare does not pay.¹² These individuals are at risk of not receiving the healthcare they need.

Although much of the growth in the Mexican-origin population results from high fertility, immigration contributes significantly to the overall increase. Traditionally, immigrants have been selected for youth and good health. Many studies show that immigrants and the foreign-born are often in better health than the native-born population.^{49–52} Mexican immigrants are not only healthier than native born individuals but also healthier than nonmigrants who remain behind in Mexico.⁸ Yet, the reality is more complicated because the migration experience itself is usually motivated by economic factors, and as part of this, migrants experience economic hardships and other strains that can undermine their mental health and impede their social integration. The strains associated with migration may be particularly serious for those who migrate in mature adulthood and old age because of a diminished capacity to learn a new language and culture and adapt to new circumstances.^{53,54}

Many older immigrants have spent their lives toiling in harsh and dangerous conditions for very low pay and have been exposed to dangerous materials. Exposure to environmental toxins and the lack of regular health-care can result in serious health problems in later life, and a lifetime of low pay means that most older immigrants were never able to accumulate significant material resources.⁵⁵ Because of inadequate healthcare in their country of origin, many immigrants may not be in good health when they arrive in the United States. They often find themselves dependent on family members, thereby impeding the ability of the family to accumulate assets.⁵⁶

NONECONOMIC BARRIERS TO CARE

Among immigrant groups, individuals have varying levels of English proficiency and social competency in their new environment. A lack of fluency in the host language and an inability to navigate the institutions of the new society are handicaps to social advancement. Previous research documents serious disadvantages in assimilation associated with older age

at migration.^{53,57} Although immigrant children quickly learn English, many older immigrants never become fluent.⁵⁸ They have elevated risk of depression and face serious difficulties in accessing healthcare.⁵⁹

Although this article is focused on the negative aspects of immigration and minority group status, data suggest that minority communities and families may protect individuals from certain negative health risks. Incorporation into a group that reaffirms one's cultural identity and provides positive social involvement can improve health, and group involvement can foster or encourage positive health behaviors.⁶⁰ Recent findings indicate that residents of high-density African-American, Mexican and Cuban American neighborhoods are in better health than those living in lower-density neighborhoods.^{61–63} Evidence suggests that religious involvement protects health generally and helps moderate the effects of the chronic conditions that accompany aging.⁶⁴ Evidence from the Hispanic EPESE suggests that older Mexican American Catholics experience mental health benefits from frequent church attendance.⁶⁵ Coreligionists and fellow church members can help older individuals with health problems remain in the community.⁵⁴ In the absence of this kind of support, a nursing home or serious isolation might be the only alternatives.

CONCLUSION: THE ROLE OF THE NEW INSTITUTIONAL ECONOMICS AND SOCIOLOGY IN UNDERSTANDING HEALTH DISPARITIES

As this brief review reveals, group differences in health risks and access to health-care result from historically based processes that place certain groups at a structural disadvantage relative to others. These disadvantages operate over the life course to place certain individuals at high risk of functional limitations, chronic disease, and death in mature adulthood. The Mexican-origin population enjoys a more favorable mortality profile than the African American population, yet older Mexican-origin individuals report high levels of functional incapacity and suffer the consequences of serious chronic disease. Although this paradox has received a good deal of research attention, the reasons for it are poorly understood. It is not clear how society, the Mexican-origin community, and individual families will cope with the increasing burden of late-life disability in older family members.

Even a casual review of the literature makes it clear that race and Mexican-origin are politically based, rather than genetically or culturally based, categorizations that reflect the political response to the historically based social and economic disadvantages experienced by certain groups. Supposed culturally based health beliefs and practices, including those related to the individual's and the community's response to illness, are intimately tied to social structural and economic factors. The attempt to assess the relative contribution of cultural, social structural, and medical care system factors to healthful aging is, as a consequence, a difficult and perhaps futile task. The potential interactions among cultural and structural factors are numerous and no doubt context-specific. Yet, dealing explicitly with the effects of structural and organizational factors is imperative if we are to gain a better understanding of how social policy and the organization of the labor market and the healthcare delivery system affect the life-long opportunity structures available to minority Americans and how those affect health over the life course.

For minority Americans, the structured and institutional inequalities that have impeded economic and social progress in the past and that continue to operate today, often in subtle ways, have their basis in a history of racism and systematic exclusion from opportunities for economic and social advancement. The task before us is to understand how social arrangements become institutionalized in ways that disfavor certain groups over generations. New insights into the operation of systems and organizations that are offered by the new institutional economics and organizational and economic sociology offer hope for increasing our understanding of group-based structured disadvantage.^{66,67} For African Americans and Hispanics, almost every aspect of social service delivery, educational opportunities, and employment has been influenced by group-specific historical processes.^{68,69} The new institutional economics and institutional sociology make specific the fact that the “rules of the game” that define institutions, including legal structures and entitlement programs, are influenced by political and economic power. Structured differences in a group’s access to power have direct impacts on the health and well-being of entire communities.¹⁸

Although African Americans and Hispanics have clearly participated in the American dream and are increasingly entering the middle class as groups, they lag far behind non-Hispanic Whites in personal and collective wealth, as well as political power. Theoretically and practically, then, dealing with issues of poverty, powerlessness, and structured disadvantage are core epidemiologic concerns. A major objective of future research should be to better understand the pathways to disadvantage and the ways in which health vulnerabilities are passed from one generation to the next as the result of institutionalized impediments to mobility, including those that are the unintended results of poorly planned social policies.

If the institutional sources of disadvantage for certain groups have not received sufficient attention in health services and other research in the United States, then the explanation may lie in the most heavily subsidized methodologies for studying health disparities. Studies that take the individual as their basic unit of observation and analysis have, for the most part, not been accompanied by major attempts to understand the role of larger social structures that perpetuate racial- and ethnic-based stratification and that give rise to less favorable individual, family, and community health profiles. A major reason for this focus on individual factors reflects that federal funding and rapid development of survey research, as well as the introduction of sophisticated quantitative techniques, have pushed researchers in the direction of survey-based epidemiologic and health survey studies. Such techniques do not necessarily lend themselves immediately to the inclusion of complex structural or organizational factors.

Major funders, including the federal government, have tended to shy away from politically sensitive topics related to structured social differences and focus on individual risk profiles. The power of individual-level biologic approaches has manifested itself in the recent impetus to fund research projects focused on genetics and biology.⁷⁰ Such approaches and motivations are based on powerful research tools that address problems that lend themselves to such techniques. Yet, the health profiles of communities and groups continue to be influenced by factors well above the level of the cell or even the individual. They are affected by the adequacy of public health initiatives and by federal and state healthcare and other social policies. Beyond that, health levels are affected directly and indirectly by

education, poverty, housing, physical and social environmental stressors, as well as social exclusion and discrimination. These are emergent phenomena that cannot be understood based solely on individual-level studies.

Our research agenda into healthful or successful aging must build upon and add to the biomedical model of disease and illness and include a broader definition of health to include its social, organizational, and institutional sources. A more comprehensive and useful conceptual model of healthful aging might well begin with a definition that includes the absence of disease and physical infirmity at its core, but that also includes institutional and structural components and factors, such as educational opportunities, good housing, and safe neighborhoods that have been shown to foster good health. New studies of healthful aging should examine the underlying determinants of illness in the community and develop better conceptual models and methods for assessing the structured and institutionalized stresses of life that minority Americans experience.⁷¹ To identify the major threats to healthful aging, we must understand how specific social structures affect not only individual-level health-related behaviors but also patterns of social interaction, the risk of victimization, perceived discrimination, the community's sense of collective security, and the rest of the package of factors that are associated with poverty and powerlessness that influence health and functioning at all ages.

Growing evidence shows that the prevalence of chronic diseases is affected by genetics, diet, and other lifestyle factors that work over a lifetime. Yet, the expression of genotypic characteristics is influenced by environment; genetics no doubt operates in complex interactive ways with factors associated with poverty and social class to determine health outcomes. In the past, the poor were thin because of a lack of food. Today, the poor are often seriously overweight and suffer the consequences of a different form of malnutrition. Given the pervasiveness of the structural disadvantages that minority Americans face in the labor force and elsewhere and the entrenched poverty and social disorganization characteristic of poor neighborhoods and communities, public health efforts focused solely on individual behaviors are unlikely to be successful in improving population health levels.

I end with a call for the introduction of the perspectives of the new institutional economics and organizational and political sociology into the study of differential health levels, including health outcomes in mature adulthood. Rather than a call for a new approach, this appeal is more a call for a return to the sorts of institutional sociology represented by the work of Eliot Freidson and others. With the dominance of survey-based approaches in the study of differential health levels and healthcare access and use, a sophisticated and informed focus on the institutional levels has lagged. In the majority of health services research, institutional and structural factors enter individual-level statistical models indirectly through controls for the presence of private health insurance, Medicaid, Medicare, or some other coverage, and through controls for income and education. Certain hierarchical techniques include ecologic and larger geographic characteristics, but even these do not address the question of how institutionalized discrimination, specific organizational structures, or formal aspects of public policies influence the health of specific groups. Given the fact that education, income, and wealth are determined as much by opportunity structures as by personal choices, understanding how those structures are maintained and

how they operate to influence health risks over the life course represents a necessary additional step in our understanding of racial and ethnic health disparities.

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Table 1

Percentage of men and women reporting chronic conditions

	Non-Hispanic Whites		Non-Hispanic Blacks		Mexican Americans	
	Male	Female	Male	Female	Male	Female
65–74 y						
High blood pressure	44.8	53.4	53.8	71.5	37.4	49.5
Cancer	17.2	13.7	8.0	9.3	5.8	7.2
Diabetes	19.2	15.1	20.0	29.8	32.1	28.1
Hip fractures	2.8	3.9	2.3	1.9	1.9	2.7
Fractures—other than hip	19.8	29.4	14.9	16.3	12.0	16.3
Heart attack	24.9	10.1	13.3	11.5	10.9	8.3
Stroke	10.6	4.0	9.3	9.5	6.9	4.1
75–84 y						
High blood pressure	42.3	51.2	46.1	66.7	32.1	53.0
Cancer	26.0	18.0	5.4	6.2	7.8	6.2
Diabetes	11.0	9.8	22.8	23.6	21.8	24.1
Hip fractures	3.8	6.8	3.9	2.9	5.5	9.4
Fractures—other than hip	21.7	35.5	13.2	16.2	10.1	16.8
Heart attack	12.8	15.8	14.6	15.1	13.3	15.1
Stroke	14.2	6.1	10.1	8.2	11.9	13.3
85± y						
High blood pressure	25.0	50.7	42.1	59.1	32.5	55.3
Cancer	22.7	16.1	9.3	8.2	7.7	12.2
Diabetes	10.4	14.3	13.6	13.7	17.4	17.2
Hip fractures	8.1	17.1	6.5	4.0	4.6	15.8
Fractures—other than hip	15.3	34.2	18.7	20.0	11.9	15.7
Heart attack	10.1	14.4	13.6	19.8	17.1	10.7
Stroke	19.8	16.9	10.7	9.0	10.1	13.5

Data from 1990 Duke Established Populations for Epidemiologic Studies of the Elderly and 1993–94 Mexican American Established Populations for Epidemiologic Studies of the Elderly.

Table 2

Percentage of individuals with major functional impairments by age

	Women					
	65–74 y			75–84 y		
	White	Black	Mexican American	White	Black	Mexican American
Heavy housework	34.5	41.2	42.2	59.5	53.5	65.4
Climb stairs	13.6	19.2	21.1	27.3	29.7	41.5
Walk half a mile	18.6	23.0	23.3	41.5	40.9	48.4

	Men					
	65–74 y			75–84 y		
	White	Black	Mexican American	White	Black	Mexican American
Heavy housework	27.7	28.3	22.8	38.4	48.5	49.6
Climb stairs	10.8	14.3	12.0	14.6	20.1	27.5
Walk half a mile	14.3	17.6	14.8	21.9	30.9	32.3

Data from Duke Established Populations for Epidemiologic Studies of the Elderly, Volume II, 1990. Hispanic Established Populations for Epidemiologic Studies of the Elderly, 1993–1994.

Healthcare coverage from major sources for Non-Hispanic Whites, Blacks, and 3 Hispanic groups, 65 years and older

Table 3

Type of coverage	Non-Hispanic White	Non-Hispanic Black	Mexican origin	Cuban American	Puerto Rican
Private, %	66.0	39.1	28.6	18.7	31.4
Medicare, %	96.5	93.2	88.4	94.9	93.2
Medicaid, %	6.6	19.3	24.2	28.3	25.0
Military, %	7.4	4.6	3.4	0.6	6.7
None, %	0.5	2.1	6.9	1.9	2.3

Data from 2004 and 2006 Annual Social and Economic Supplements, *Current Population Survey*.