Race/Ethnicity and Nativity Differentials in Self-Care Limitations for Men and Women in Later Life

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Race/ethnic and nativity disparities in U.S. health are both pervasive and well documented in the literature. In addition, health disparities by race begin early in the life course and not only persist, but appear to increase in mid-life and into late life (House et al. 2005; Kelley-Moore & Ferraro 2004). For example, black individuals have a higher incidence of disease, lower self-rated health and live substantially more years with disability than whites (Elo & Preston, 1994; Geronimus et al., 2001; Hayward & Heron, 1999). In addition, most U.S.-born minority groups experience socioeconomic disadvantages in part due to structural racism and the hierarchical nature of the U.S. stratification system. With the minority population aging rapidly in the near future, more research on older minority sub-groups is critical. In particular, it will be important to better understand race/ethnic patterns of physical functioning, disability, and the use of accommodations to facilitate functioning and mobility as currently disadvantaged groups become a much larger share of the older adult US population.

The goal of this paper is to examine race/ethnic and nativity differences in self-reported measures of self-care tasks. I will also analyze the extent to which social environmental characteristics work to narrow the gaps between sub-groups. I use data from the 2011 NHATS to investigate the following research questions: 1.) Are there race/ethnic and nativity differences in the ability of individuals to perform essential self-care activities? 2.) To what extent do socioeconomic and social characteristics, health conditions, physical capacity, and accommodations explain race/ethnic, and nativity disparities in self-care?

Population based studies on disability typically measure only one of the components of the disablement process, generally ADLs or IADLs, since they are well established measures of how disability manifests in social roles such as difficulty carrying out activities that are essential

for living independently. Although the traditional ADL and IADL measures are well-established indicators of disability, these measures have not changed in nearly half a century. This is potentially problematic since the way in which we carry out activities of daily living has changed a great deal over the past few decades, with technology and assistive devices making it easier for the elderly to navigate their environment, even for those who have some limitations and ADL/IADLs. For example, older individuals can utilize hand grips to bathe without assistance, technology to bank and shop without leaving the home, and the microwave to heat frozen meals. Access to assistive devices and technology is not distributed equally across the older population, however, so it stands to reason that less advantaged individuals will be less likely to utilize these accommodations and therefore will report higher levels of disability.

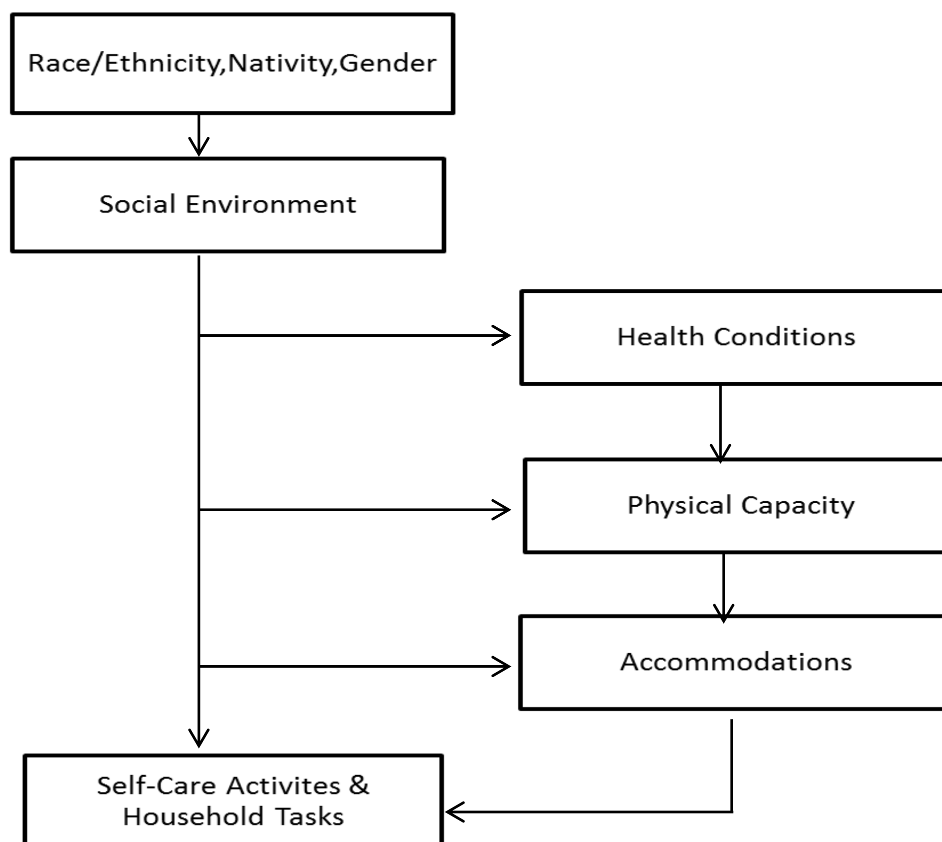

Figure 1: Conceptualization of Race/Ethnicity, Nativity, Gender, Social Environment, and Older Adult Self-Care and Household Activities.

In light of these conceptual and measurement challenges, I propose a framework (Figure 1) that is informed by the traditional disablement model and draws heavily from the NHATS framework and measures (Freedman, 2009). In contrast with earlier frameworks, however, I posit that the primary pathway for disability and functioning starts with race/ethnicity, nativity, and gender. These demographic factors are dimensions of stratification that shape health outcomes throughout the life course. It has long been established that there are significant race/ethnic differences in health that are primarily based on social and environmental inequality (Du Bois, 1899). In addition, these racial gaps are gendered, with gaps for men larger than those for women. The higher rates of chronic disease and disability for racial minorities reflect earlier onset of disease, greater severity, and worse survival rates (Williams et al., 2010). I include gender as a primary pathway in my conceptual framework as well since it is well established that health patterns are gendered (Verbrugge, 1985; Bird & Rieker, 2000). Although women have longer life expectancies than men, they spend more years with disability and chronic illnesses (Crimmins et al, 1996). Race/ethnicity, nativity, and gender are closely tied to primary environmental influences, which work to structure the entire health process. Thus, for example, socioeconomic resources such as income, education, and wealth may be thought of as key environmental resources that shape race/ethnic and nativity disparities in chronic conditions, functional limitations and subsequent disability. Other factors included in the social environment are marital status and living arrangements Much like the NHATS, this conceptual framework preserves the traditional measures of functioning, modernizes measures of disability and expands their scope, and adds new measures that help assess how functional changes unfold in later life (Freedman et al., 2011).

Data

The data for this paper come from the first round (2011) of the National Health and Aging Trends Study (NHATS). The sample size for this analysis is 8,245 individuals, with 468 of the respondents in nursing homes/residential care facilities. My dependent variable, self-care

activities, is composed of four items. These include eating, getting cleaned up, toileting, and dressing. My primary independent variables of interest are race/ethnicity, gender, and nativity. I also examine the social environment through measures of household income, education, living arrangements, and marital status and control for health conditions and physical capacity/functioning.

Methods:

First I will run age-standardized descriptives for each race/ethnic and nativity sub-group (U.S.-born and foreign-born whites, blacks, Hispanics, and "other") to examine differences in the social environment measures (education, household income, living arrangements, and marital status), as well as the measures of self-care, health conditions, physical capacity, and accommodations .To address the first research question regarding the differences in performance of self-care activities, I will look at differences in the number of self-care limitations for each of the race/ethnicity/nativity groups. To do this I use Poisson Regression to take into account the number of self-care limitations. I will add each group of measures in five separate models (basic demographics, social environment, health conditions, capacity, and accommodations) to determine whether they help to explain differences in self-care between groups.

Expected Findings:

My preliminary findings suggest that there are race/ethnic and nativity differences in prevalence of self-care limitations before controlling for socioeconomic factors. In particular, U.S.-born black women and men have higher rates of limitations than their non-Hispanic white counterparts. I expect to find these disparities attenuated once I control for socioeconomic factors such as family income and education. However, I also expect to find that minority and foreign-born sub-populations continue to experience worse health outcomes even after controlling for SES, marital status, chronic conditions, and use of technology/assistive devices. Ultimately, I feel that these findings can inform health policy for our rapidly aging and increasingly diverse society.

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