The Aging Hispanic in America: Challenges for Nurses in a Stressed Health Care Environment

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The explosion of immigration of the Hispanic population into the United States in recent years has placed considerable challenges on a health care system that is chronically overburdened and inadequate. According to Markides and Gerst (2011), over half (53.1%) of immigrants coming to the United States are from Latin America. It has been suggested the Hispanic population from Mexico, and Central and South America has surpassed African-Americans as the largest minority population in the United States. According to the 2010 census, over the past decade the Latino population has increased from 35.3 million in 2000 to 50.5 million in 2010. Specifically, the number of older Hispanics will increase from just fewer than 1.8 million in 2000 to more than 8.6 million by 2030 (Ennis, Rios-Vargas, & Albert, 2010). As this elderly population grows rapidly, the need for long-term care as well as general health care is likely to increase substantially.

Many subgroups of Hispanic populations have distinct cultural beliefs and traditions. For certain health conditions, older Hispanics bear a disproportionate burden of disease, injury, death, and disability when compared with non-Hispanic White elders, the largest racial/ethnic population in the United States (Administration on Aging, 2010). By 2050, programs and services for older people are expected to require greater flexibility to meet the needs of a more diverse population (Federal Interagency Forum on Aging-Related Statistics, 2008). Despite progress, ethnic disparities persist with elderly Hispanics trailing elderly non-Hispanic Whites in the leading indicators of health (Centers for Disease Control and Prevention [CDC], 2007). In this article, the significant challenges facing aging Hispanics will be addressed and strategies to sensitize caregivers to the important role culture and ethnicity play in the delivery of quality health care will be suggested.

Background and Historical Perspectives

The word disparity can be defined as "containing or made up of fundamentally different and often incongruous elements" (Merriam-Webster Online, 2009). Synonyms for disparity include inequality, unlikeness, disproportion, and difference. Disparity in health care has been associated closely with inequity, with several potential reasons for the differences observed at the individual level (Agency for Healthcare Research and Quality [AHRQ], 2007). According to Levine and colleagues (2011), ethnic disparities in care are explained largely by differences in English fluency, but racial disparities in health care are better explained by delayed care due to a lack of cultural and ethnic knowledge of caregivers, lack of insurance, and lack of transportation. While goals of Healthy People 2020 include the decrease of ethnic
disparities in health care, there is still much work to do as considerable ethnic disparity continues to exist (Healthy People, 2012).

Racial and ethnic disparities in health affect care at all levels, including insurance coverage, access to care, quality of care, and the outcomes of care (Levine et al., 2011). According to Carter-Pokras and colleagues (2012), health behaviors, policies, and interventions can have an impact on health care disparities. Integration of health disparity assessments into policy planning and implementation may ensure health disparities lessen among those experiencing health inequalities.

According to Healthy People 2020, the goal of recognizing and attending to health disparities has not been met (U.S. Department of Health & Human Services, n.d.). Ethnic and racial disparities continue to persist as being problematic among the leading indicators of good health. Hispanics lagged behind non-Hispanic Whites in a variety of health care measures such as lacking appropriate health care insurance (CDC, 2007). According to Luo (2012), a large percentage of Hispanics were uninsured and were forced to seek medical care in emergency departments. Hispanic adults age 65 and older also were vaccinated at a lower rate against influenza and pneumococcal disease (CDC, 2007). Studies have found racial discrimination has harmed the health of these individuals within and across the socio-economic strata, and has contributed to racial and ethnic disparities in inadequate health care (Mays, Cochran, & Barnes, 2007; Toporowski et al., 2012; Williams & Mohammed, 2009).

The landmark report Unequal Treatment: Confronting Racial and Ethnic Disparities in Care noted ethnic disparities continue to persist in medical care for a number of health services and conditions (Institute of Medicine [IOM], 2002). The shortage of well-trained bilingual-bicultural clinical researchers, as well as the use of proficient assessment instruments, has been a negative influence on the diagnosis, management, and service utilization pattern of the Hispanic population (Anderson & Ofayiwola, 2012). Barriers to health care access for older Hispanic adults are determined by health care delivery policies and services that do not consider cultural variability (Carter-Pokras et al., 2012). Health care providers also may be less likely to practice racial bias; however, due to the complexity of care, time constraints, and high-pressure situations, they may rely on stereotypes or subconscious bias (Anderson & Ofayiwola, 2012).

When comparing care of patients with similar incomes and insurance, disparities existed among ethnic groups (Otiniano & Gee, 2011). The Kaiser Family Foundation (2006) reviewed studies from 1984 to 2001 investigating ethnic differences in cardiac care, and provided credible evidence of lower rates of diagnostic and revascularization procedures for Hispanics. Substantiation of racial/ethnic disparities among individuals with comparable insurance and the same illness has been most troubling because health insurance coverage is less likely to be available to older Hispanics (Toporowski et al., 2012).

Through the establishment of national goals on eliminating health disparities, the U.S. Department of Health and Human Services (n.d.) has provided impetus on addressing disparities. This has resulted in the decision to have one set of goals for all Americans, rather than separate goals for the health of non-Hispanic White and minority populations. These goals also have helped to center public and private attention on ethnic disparities in the health care system (Toporowski et al., 2012).

**Description of Challenges**

Many challenges exist related to health disparities in aging Hispanics. Challenges may be related to numerous health issues, language difficulties, differences in cultural beliefs and practices, and the loss of social supports. Of the health issues, over 50% of those with Alzheimer’s disease have not been diagnosed, and missed diagnoses appear to be more common among Hispanics (Health Promotion and Chronic Disease Division, 2011). According to national examination surveys, Hispanics were almost twice as likely as non-Hispanic Whites to be diagnosed with diabetes by a physician. They also had higher rates of end-stage renal disease caused by diabetes, and were more likely to die from diabetes than non-Hispanic Whites (The Office of Minority Health, 2012). Approximately 14,000 Hispanic men and 14,000 Hispanic women were expected to die from cancer in 2009 (American Cancer Society, 2011). Among men, lung cancer was expected to account for about 22% of total deaths, followed by colorectal (11%) and liver (11%) cancers. Among women, breast cancer was the leading cause of cancer death (15%), followed by cancers of the lung (13%) and colorectal cancer (American Cancer Society, 2011).

Nurses and other health care professionals must realize the importance of using clear communication skills with individuals from different cultures, and the need to understand and value their health beliefs and practices (Ellison, Jandorf, & Duhamel, 2011). Although access to health care does not account for disparities in their entirety, physicians and health care workers do contribute to a portion of disparity problems. In addition, contributors to these health disparities include institutionalized discrimination, where policies and procedures make it harder for health care professionals to provide equal care to disenfranchised individuals. A variety of factors, such as cultural beliefs, social supports, socioeconomic status, and cultural values, may affect the use of the health care system (Barragan, Ormond, Strecker, & Weil, 2011).

Acculturation is the process of changes in behavior and values that occur when individuals encounter a new group, notion, or culture (Ellison et al., 2011). The inability to acculturate may play a large part in the lack of adherence to recommended health care measures in elder Hispanics. Some elder Hispanics may have cultural beliefs and values that conflict with traditional Western health care views, leading to a failure...
to access care. Frequently reported is the Hispanic belief that physical and mental illness results from an imbalance between the person and environment, and between hot and cold. If an illness is deemed a hot disorder, then the treatment should consist of interventions considered cold. Hot diseases or conditions include pregnancy, hypertension, diabetes, and acid indigestion. Examples of cold diseases or conditions include menstrual cramps, pneumonia, nosebleeds, and colic. Standard practice would be to treat a nosebleed by applying an ice pack. However, this is an unaccepted practice in the Hispanic culture because it involves treating a cold condition with a cold treatment. These cultural beliefs may not be shared with the health care provider and may result in problems relating to adherence with the treatment plan (Barragan et al., 2011). To avoid such problems, the nurse should be respectful when working with persons of different backgrounds and allow patients to be contributors to their treatment plans.

Health care providers and caregivers have questioned if a lack of access to care has discouraged the use of preventive care, such as physical, dental, and eye checkups; Papanicolaou smears; and breast examinations. Without the ability to understand and communicate, some elder Hispanics may be less likely to understand or take advantage of preventive services. Evidence suggests the health habits and health status of Hispanics deteriorate with length of stay in the United States. When individuals do not acculturate, it is more likely that succeeding generations may experience a poor health status. The process of acculturation and the type of cultural contact experienced in migration among Hispanics are stressful because of the disruption of attachments to supportive networks, and the difficult tasks of adapting to the economic and social systems in a new country (Ellison et al., 2011).

Many Hispanics enter the United States as migrant workers and are more likely to experience discrimination and exclusion that may delay improved social and economic status as they attempt to adapt to American culture and values (Toporowski et al., 2012). Multiple challenges confront immigrants as they adjust to their identity as members of a minority and attempt to acculturate. Their vulnerability is exposed as they are compelled to abandon major parts of their cultural values and beliefs (Ellison et al., 2011). This acculturation may include the abandonment of culturally tied health beliefs as well as the loss of culturally tied resources and social support networks, which may place them at risk for depression or other mental illness (Taylor, Chatters, & Nguyen, 2012).

Citizens born in this country are more likely to be insured than immigrants entering the country. Overall, immigrants appear to have lower rates of employer-sponsored insurance and are reluctant to rely on public-sponsored coverage programs. According to Viruell-Fuentes, Miranda, and Abdulrahim (2012), even though more than 80% of immigrant families have at least one full-time worker, that worker is more likely to work in a job that does not offer health insurance coverage. These disparities in insurance coverage become more evident when comparing low-income residents with others. Experiencing a health disparity is most likely related to the lack of health insurance, creating additional problems with access to health care. Problems may include securing a regular source of care, visiting a primary care provider in a given year, or obtaining preventive care. The absence of health insurance also can place considerable financial strain on low-income families who are required to seek care without any financial resources.

Strategies

Strategies used by uninsured persons include delaying care or ignoring treatment; sharing medication, often inappropriately; or using false identification to visit emergency departments. Cases have been reported of non-English-speaking Hispanic workers being abandoned at emergency departments by employers afraid of reprisal for hiring illegal immigrants. In a study by Becker (2008), respondents reported the following deterrents to seeking health care: the hassle factor in obtaining safe health care, mistrust of primary care providers and the quality of care, and inability to communicate because of language differences. The experience of discrimination, whether attributed to being uninsured or being a member of an ethnic minority, was an additional affront. Clearly, people forced to seek health care perceived they were treated differently than if they were insured, which reinforced their antipathy toward the health care system. Although health providers may not intend their interactions with patients to be discriminatory, people who are uninsured often perceive discrimination and question if their care is the same as persons with insurance. Dissatisfaction is a deterrent to health care, and consequently people may seek health care only when they believe it is essential.

Hispanics age 65 and older have fewer retirement income sources than non-Hispanic persons in the same age group; in addition, fewer elder Hispanics have income from Social Security, any kind of pension, interest earnings, or dividends. The poverty rate for Hispanics age 65 and older is twice that of all others in the same group. For many older Hispanics, Social Security may be their only source of income, and they may rely far more on this source than other retirees do. Presently, the poverty rates for older Hispanics are double that of all non-Hispanics age 65 and older. Without Social Security benefits, over 54% of older Hispanics would live below the poverty level (Issa & Zedlewski, 2011).

Many Hispanics present with co-morbid symptoms, which makes diagnosis difficult. For instance, mental illness may be coupled with other leading causes of disease among elder Hispanics, which most often are noted as co-morbid issues. Hispanics diagnosed with mental and physical illness may find themselves lacking health care (Cook, McGuire, Alegria, & Normand,
2011). General concerns for elder Hispanics address accessibility to quality services, affordability of those services, cultural and linguistic adequacy of the available services, and the ability of providers to understand the Hispanic-specific issues confronting members of that community (Toporowski et al., 2012).

Certain health problems, including diabetes and cardiovascular disease, disproportionately affect the Hispanic community and can exacerbate depression. According to Mier and colleagues (2012), older Hispanic adults are at high risk for depression for many reasons, including normal aging as well as the loss associated with leaving homes and moving to a new country. Diabetes affects an estimated one-third of older Hispanics, and the risk of depression among elders with diabetes is 30% higher when compared to elders without diabetes. The combination of diabetes and depression, which is most common among older Mexican Americans, may develop because of stress and the metabolic effects of diabetes on the brain, or from issues of immobility.

Hispanics experiencing the co-morbid states of depression and diabetes are more likely to experience higher resting blood glucose levels, less likely to see a physician and practice routine self-glucose monitoring, and more likely to report severe depressive symptomology and problems with activities of daily living. Unfortunately, Hispanics with diabetes and co-morbid depressive symptomology also are more likely to experience strokes, kidney disease, heart attacks, and amputations (Cimpean & Drake, 2011). As further impairment occurs due to co-morbid exacerbation without adequate treatment, elder Hispanics become at greater risk for memory loss and may become unable to function independently, creating a greater risk for institutionalization (AHRQ, 2007).

Cardiovascular disease (CVD), the leading cause of death among Hispanics, also affects mental health status. Depression is an independent predictor of cardiovascular disease and results in greater morbidity and earlier mortality in persons with CVD (Niranjan, Corujo, Ziegelstein, & Nwulia, 2012). Moschetti, Cummings, Sorvillo, and Kuo (2012) examined elder Hispanics with Alzheimer’s disease and other age-related dementias, and found the dementias were responsible for increased health care costs, disability, and lost productivity for patients and family caregivers.

The IOM Study Committee for Unequal Treatment recommended the use of a comprehensive, multi-level strategy to address potential causes of ethnic disparities in care that arise at the level of the patient, provider, and health care system. The recommendations point to five broad areas of policy challenges: raising public and provider awareness of ethnic disparities in care, expanding health insurance coverage, improving the number and capacity of providers in underserved communities, improving the quality of care, and increasing the knowledge base on causes and interventions to reduce disparities. These recommendations provide an important foundation for addressing health and health care disparities (Warnecke et al., 2008).

**Nursing Implications**

Whether through providing care in emergent or acute care settings, or assessing patients in an outpatient clinic, nurses may be the first health care providers who come into direct contact with elder Hispanics. They need to gain expertise when interacting and caring for older adults of Hispanic ethnicity. According to the CDC (2008), poor health outcomes in Hispanic populations can be attributed to language and cultural barriers, as well as lack of health insurance and access to preventive health care. Recommendations to address this concern include increasing the number of Spanish-speaking nurses so communication barriers may be overcome (Piedra, Andrade, & Larrison, 2011). An estimated 23% of first-generation Hispanic immigrants speak little or no English (Hakimzadeh & Cohn, 2007). Minimally, mastery of commonly used phrases and medical terminology in Spanish is recommended. Nurses learning Spanish and participating or teaching in English as second language courses will begin to address the communication barrier in providing basic health care to Hispanic elders.

Education regarding Hispanic cultural practices, values, health practices, beliefs, and the differences regarding family-centered treatment is a necessity for nurses (Piedra et al., 2011). Advancing their knowledge about the Hispanic culture is critical, and nurses need to make their education a priority. Accrediting bodies require schools and colleges of nursing to include diversity and cultural competence content in their curricula (DeSantis & Lipson, 2007). Health care agencies also need to provide continuing education opportunities to help practicing nurses become more culturally competent. Education on the progression of normal aging and the unique characteristics associated with the Hispanic population is necessary for professionals who provide care to Hispanic elders. Participating in training to detect mental health problems among Hispanics; routinely screening patients for diabetes, cardiovascular disease, and infectious disease; and having the opportunity to engage in Hispanic-specific health care training to remain abreast of research and programmatic strategies are critical to providing Hispanic elders with culturally competent health care (Piedra et al., 2011).

In addition to Spanish language and cultural competence education for nurses, patient education materials in Spanish to address prevention and treatment of commonly occurring disorders are useful. Nurses should be aware of web sites that provide excellent patient education materials developed for the Hispanic population. For example, the CDC (2008) provides patient education resources in Spanish that can be used with elders.

As the United States becomes increasingly diverse, health care providers are challenged to expand their knowledge of minority populations and health care disparities.
Health care providers need to develop new skills and cultural competencies to care for these patients effectively and efficiently. Formal nursing education programs should provide preparation in learning the underlying causes of health disparities and include information on health care access, resources, treatments, and outcomes. Failure to respond effectively to the needs of minority communities may have severe health consequences (Toporowski et al., 2012).

Conclusion

Critical challenges for health care providers include social determinants of disease distribution and the underlying inequalities in access to and benefit from preventive services and health care, particularly within the growing Hispanic population in the United States. Amidst these increasing health disparities, a focus on the structural factors that influence the health care of elderly Hispanics is necessary to develop better multilevel interventions that promote culturally competent health care.

REFERENCES


