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This study employs data from the 1993–94 Hispanic Established Population for Epidemiological Studies of the Elderly (H-EPESE) to assess the impact of nativity on preferences in living arrangements for a sample of 3,046 Mexican American individuals over the age of 65. Our results reveal great differences between the native and foreign-born in their desire to live with their children. A larger fraction of the foreign-born than native-born currently live with their children and state that they would care to continue living with their children in the event that they could no longer care for themselves. The data also reveal that the foreign-born face more serious economic constraints than the native-born and suggest that living with children may be motivated in part by economic need. We end by speculating on the implications of these findings for community-based care for elderly Mexican Americans.

Key Words: Minorities, Nativity, Disability

Nativity, Declining Health, and Preferences in Living Arrangements Among Elderly Mexican Americans: Implications for Long-term Care[1]

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The population of the United States, like that of most other nations of the world, will age rapidly well into the twenty-first century. The consequences of this population aging have been debated in numerous arenas, most recently in conjunction with the growing cost of medical and long-term care of the elderly (Mendelson & Schwartz, 1993; Newhouse, 1993). It is clear that we are entering a new era in human history in which aging populations present unique problems to both developed and developing nations. For the most part, scholarly debate over the effect of aging populations has focused on the consequences of the relative size of the older population on aggregate spending for social welfare (World Bank, 1994). Clearly, the fact that both the number of older individuals and the proportion of the population they represent is rapidly increasing has important implications for all aspects of social policy. Yet the relative size of the older population is not the only, and perhaps not even the most important, factor that will affect social policy relating to long-term care in the near future (Oriol, 1994). As important as the size of the elderly population is for policy planners, the consequences of the increasing racial and ethnic heterogeneity among the population over 65 may be even more important.

Because of higher fertility and differential immigration patterns among certain groups, an ever larger fraction of the older population consists of individuals who are members of racial and ethnic minority groups (Angel & Hogan, 1992). The long-term medical care needs and preferences in living arrangements of these subgroups of the elderly population may differ significantly from those of the majority (Angel & Angel, 1992; Burr, 1990; Burr & Mutchler, 1992; Frisbie, Bean, & Poston, 1985; Thomas & Wister, 1984; Worobey & Angel, 1990). Long-term care policies that are based on the assumption that the elderly are homogeneous in terms of their health care needs and preferences in living arrangements are very likely to be plagued by inefficiency (Williams, 1994). In this article, we argue that in order to develop long-term care options that optimize the quality of life among older individuals in a politically realistic and cost-effective manner, we must first understand the needs and preferences of specific subgroups. In the present case, we look at older Mexican Americans. A major focus of the study is to examine the extent to which culturally conditioned norms concerning children's obligations to care for their aging parents explain the well documented tendency for older Mexican Americans to remain in the com-

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munity and not to enter nursing homes (Burr, 1990; Eribes & Bradley-Rawls, 1978; Espino, Neufeld, Mulvihill, & Libow, 1988; Torres-Gil & Fielder, 1986–87; Worobey & Angel, 1990).

The Growing Cost of Long-term Care

Since 1965, when Medicare was introduced, the rate in the growth of expenditures for medical care under that program has increased dramatically (Feder, Rowland, Holahan, Salganicoff, & Heslam, 1993). In addition, Medicaid expenditures for hospital and physician services and long-term care for the elderly have grown at an ever-increasing rate in recent years (Rowland, Feder, Lyons, & Salganicoff, 1992; Feder et al., 1993). Currently, Medicaid provides coverage to only one third of the older population in poverty (Rowland & Lyons, 1987). Those not covered by Medicaid must rely on Medicare alone, managing somehow to cover the premiums, deductibles, and copayments out of current income, or they must do without services. Providing supplemental coverage to all poor elderly Americans, either through Medicaid or some other program, will add greatly to aggregate health care costs and divert money from other uses. For the foreseeable future, therefore, the forces propelling the growth in health care costs, including advances in technology and an aging population, will make it difficult, and perhaps impossible, to contain the growth in health care expenditures (Mendelson & Schwartz, 1993; Newhouse, 1993).

In the context of an aging population with an ever greater need for hospital and home health care services, the containment of the growth in expenditures for the care of older individuals will require innovations that maximize the use of less expensive community mechanisms of support (Bass & Noelker, 1987). Numerous experiments in home- and community-based care have been tried and will no doubt form a central part of any innovations in long-term care for the elderly (Rivlin & Weiner, 1988; Rowland & Lyons, 1987; Rowland et al., 1992; Weiner & Hanley, 1992). Initial hopes were that community-based care would be less expensive than institutionalization, but the evidence indicates that this is not necessarily the case (Capitman, 1986; Kane & Kane, 1990; Leutz, 1986; Vertrees, Manton, & Adler, 1989; Weiner & Hanley, 1992). Because of the large number of individuals in the community who might benefit from community services but who do not receive them, providing such services could increase use among these individuals and result in higher program costs (Hanley, Weiner, & Harris, 1991). Nonetheless, in light of the continuing growth in health care costs, especially those associated with long-term care, community-based programs continue to hold great potential for the support of individuals with intermediate levels of need.

It is clear that the family shoulders the greatest burden in caring for infirm older individuals, especially among minority elderly persons (Brody, 1985; Doty, 1986; Greenberg & Becker, 1988). Even when they suffer from fairly serious disabilities, older individuals prefer to live alone or in the community rather than enter a nursing home (McDowell, Barniskis, & Wright, 1994; Worobey & Angel, 1990). Although many receive some form of home health care, many others simply do without care or rely mainly on the assistance of family members (Soldo, Wolf, & Agree, 1990; Wallace, Levy-Storms, & Ferguson, 1995). Many programs for assisting the family by providing support to elderly parents in the community have been proposed in recent years and it is likely that in the future such proposals and programs will become common (Capitman, 1986; Doty, 1986; Horwitz & Shindelman, 1983). Due to the aging of the baby boom generation, it is imperative that we determine how such informal mechanisms of support might be augmented, rather than replaced, by formal sources (Brody, Poulshock, & Masciocchi, 1978; Cantor, 1991; Stone & Kemper, 1989; World Bank, 1994).

Most long-term care policy proposals are based on the assumption that the elderly population is homogeneous in its needs (e.g., Ladd, 1995). Fernando Torres-Gil, who is currently the Assistant Secretary for the Department of Health and Human Services Administration on Aging, notes that, while "Long-term care programs and benefits generally rely on age and/or functional ability as the criteria for receiving services and assume the aged population is homogeneous . . . it is clear that the minority elderly population is increasing and their cultural, social, and linguistic uniqueness will require that more than age and functional ability be considered in the development of long-term care policies" (1986; p. 50). This growing cultural heterogeneity among the elderly population will influence personal and family preferences in living arrangements and affect the long-term care needs of different segments of the older population (Cowart, 1994).

Although most individuals prefer to live in the community as long as possible, one's ability to do so, and the quality of one's life in the community, are affected by numerous factors. One's family situation and living arrangements determine the number of individuals available to help with basic physical activities of daily living, such as dressing and bathing, as well as with more complex instrumental tasks, such as shopping and handling finances (Litwak, 1985). Racial and ethnic groups differ significantly in living arrangements and family size, factors that influence the availability of informal support (Angel & Angel, 1992).

In addition, there is mounting evidence that cultural factors influence the role of the family in the care of elderly individuals, thereby affecting the overall assistance package that elderly individuals require (Burr, 1990; Worobey & Angel, 1990). Attempts to develop a rational system of managed care for the elderly must be informed by a better understanding of the total package of pathology different groups of elderly individuals experience, as well as an understanding of the ways in which cultural, economic, and health care system factors influence the extent of need for long-term care and specific home health care services.

> Mama Elena, you know perfectly well that being the youngest daughter means you have to take care of me until the day I die. . . . but in my opinion, you don't have an opinion, and that's all I want to hear about it. For generations, not a single person in my family has ever questioned this tradition, and no daughter of mine is going to be the one to start. . . (Laura Esquivel, *Like Water for Chocolate,* pp. 10–11).

The Mexican American population, like all other cultural groups, is unique in ways that can potentially affect the health and welfare of its elderly members. Because of high fertility and historically high levels of both legal and illegal immigration, the Mexican American population is among the fastest growing minority groups in the United States (Bean & Tienda, 1987). Mexican Americans are also on average younger than blacks or non-Hispanic whites. Yet, like the population at large, Mexican Americans have experienced decreases in mortality from both acute and chronic diseases and, consequently, the number of Mexican Americans over the age of 65 is growing rapidly. By the year 2010, the number of Hispanics in the United States over the age of 65, of whom Mexican Americans are the largest group, is projected to increase by approximately two and a half times (Angel & Hogan, 1992). Like their non-Hispanic white counterparts, older Mexican Americans will be living longer and will suffer from the chronic illnesses that accompany aging. This fact means that the cost of caring for older infirm Mexican Americans will inevitably increase (Torres-Gil & Fielder, 1986–87).

Although Mexican American fertility rates have dropped along with those of the rest of the population, the Mexican American population continues to have larger-than-average families. Furthermore, there is evidence to suggest that a traditional orientation may instill in both parents and children alike a desire for greater contact and expectations that children should be responsible for aging parents (Subcommittee on Aging, 1994). In what follows, we examine patterns in living arrangements and, for those who live with their children, their reasons for doing so. The data suggest that for older Mexican Americans, living with children is still a desirable and viable option. We also examine responses to the question of where an older individual would care to live in the event of incapacity. Our ultimate objective is to get at least a rudimentary idea of the long-term health care needs and desires of the older Mexican American population. Up until now, those desires have been purely a matter of specification or have been assumed to be identical to those of other groups.

Traditional portrayals of the Mexican-origin family convey the image of a multigenerational household governed by norms of mutual assistance and primary reliance on the family (Gratton, 1987; Griswold del Castillo, 1984). Indeed, a highly familistic orientation among Mexican Americans has been documented by demographers, ethnographers, and sociologists (Becerra, 1983, 1988; Burr & Mutchler, 1992; Markides & Martin, 1983; Sotomayor & Garcia, 1993). Some observers find that, on average, Mexican Americans do indeed have more cohesive family support systems than non-Hispanics (e.g., Angel & Angel, 1992; Becerra, 1988; Keefe & Padilla, 1987; Weeks & Cuellar, 1981). Yet, everyone is affected by social and economic change, and it is clear that for older Mexican Americans, the decision to live alone, to live with family, or to enter a nursing home is influenced by a complex set of objective factors, as well as by one's attitudes and life experiences (Weeks & Cuellar, 1981; Williams, 1990). As among non-Hispanics, many Mexican American adult children are unable to provide either financial or instrumental aid to their aging and infirm relatives (Grebler, Moore, & Guzman, 1970; Markides & Martin, 1983). In many cases, distance, low income, and inadequate housing make it difficult for the family to play the role it may have played in previous years.

The family, though, continues to offer great possibilities for the care of the elderly. Recent evidence from the Canadian Survey of Aging indicates that elderly parents would like to live with their children if they could feel certain that they would be welcome (Connidis, 1983). Many researchers have suggested that extended households may represent a response to poverty and provide the possibility of mutual aid and assistance among family members. In some cases, living with relatives may be a realistic substitute for formal care (Angel & Tienda, 1982; Kane & Kane, 1981; Litwak, 1985). Studies show that Mexican families tend to live near relatives and close friends, have frequent interactions with family members, and exchange a wide range of goods and services that include babysitting, temporary housing, personal advice, nursing during times of illness, and emotional support (Muller & Espenshade, 1985).

Method

In the following analyses, we employ data from the Hispanic Established Population for Epidemiological Studies of the Elderly (H-EPESE), a large, multistage probability sample of Mexican Americans 65 and older who reside in the southwestern states of Texas, California, New Mexico, Arizona, and Colorado (Markides, Rudkin, Angel, & Espino, in press). The present analysis is based on the first wave of the study, which consists of a survey of 3,050 individuals. The overall response rate for the respondents is 86%. All subjects were interviewed in their home for approximately two hours by trained interviewers who assessed the respondent's functional capacity and collected information on nativity status, demographics, household structure, and socioeconomic status. In the following analyses, we employ variables that capture aspects of economic and structural constraints on choices in living arrangements. For those individuals who were too cognitively or physically debilitated to participate in the study, information on objective questions was obtained from a proxy familiar with the subject. Ten percent of the completed interviews were with proxy respondents. These cases are dropped from analyses in which subjective information is employed.

Measures and Analyses. — In the first stage of the analysis, we present descriptive statistics to show the association between living arrangements, preferences in long-term care arrangements, and functional disability among native and foreign-born elderly men and women. In order to characterize their living arrangements, we employ a detailed typology of living arrangements with eight categories based on household size, marital status of the respondent, and the relationship of the respondent to the head of the household. For married individuals, the living arrangements we examine include (1) those who live only with their spouse; (2) those who live with others, but in a situation in which neither of the older couple is the head of household; and (3) those who live with others in a situation in which the older couple is the head of the household. Among the unmarried, we compare the living arrangements of (4) unmarried individuals living alone to those who live with others in four different arrangements based on sex and household headship status, (5) unmarried women heading their own household, (6) unmarried women living with someone else who is the head of the household, (7) unmarried men heading their own household, and (8) unmarried men living with someone else who is the head of the household.

We assess functional limitations using three standard scales that tap separate dimensions of disability. Two scales tap dimensions of physical disability, and the third assesses problems with more complex daily social activities. The first physical disability scale measures an individual's capacity to perform basic physical activities of daily living (PADLs) without help, and includes questions concerning bathing or showering, dressing, personal grooming, eating, transferring (getting in and out of chair), walking across a room, getting outside, and using the toilet. The second physical functioning scale (ROSOW) is a modified version of the Rosow-Breslau scale and includes three questions on gross mobility, whether the respondent needs help with heavy housework, walking up and down stairs or to a second floor, and walking half a mile (Rosow & Breslau, 1966). The third scale measures problems associated with social activities of daily living (SADLs), and includes questions concerning difficulty performing routine household chores, using a telephone, shopping for groceries, driving an automobile or traveling alone on public transportation, doing light housework, taking medicine, preparing meals, and handling money.

Results

Table 1 contrasts the native-born to the foreign-born on the basis of the eight arrangements listed above. What emerges is a clear picture of a greater familial orientation among the foreign-born. Fewer of the married foreign-born than the native-born live with only their spouse (living arrangement 1), and although only a small fraction of married couples live with someone else in a situation in which they are not the heads of the household, a larger fraction of those who do are foreign-born (living arrangement 3). In a majority of these cases, the head of household is an adult child. Among unmarried females, a smaller fraction of the foreign-born are heads of household and a larger fraction live with someone else, again usually an adult child. Although relatively few single males live with someone else when they are not the head of household, a larger fraction of those who do are foreign-born. These data, therefore, suggest that the foreign-born elderly are more likely to live with their children than are the native-born.

Table 1. Living Arrangements Among Elderly Mexican Americans by Nativity Status (Weighted Percentages)

Type	Percent	
	Native	Foreign
1. Married, live only with spouse	35.3	27.1***
2. Married, live with others, couple is head	20.1	21.7
3. Married, live with others, other is head	1.8	4.6****
4. Unmarried, live alone	21.6	19.7
5. Unmarried women heading own household	10.6	7.9*
6. Unmarried women, other heads household	5.4	13.1****
7. Unmarried men heading own household	3.6	3.2
8. Unmarried men, live with others, other heads household	1.7	2.7***
Total percent	100.1	100.0
Unweighted *N*	(1,701)	(1,345)

(χ^2 for living arrangements: native/foreign)
*$p < .05$; **$p < .01$; ***$p < .001$; ****$p < .0001$.

Table 2 contrasts the native-born to the foreign-born in terms of sociodemographic characteristics, health, and disability. The data reveal a profile that is consistent with the lesser degree of structural and economic assimilation that is typical of recent immigrants. The foreign-born live in larger households and have less education and lower household and personal incomes than the native-born. In addition, the table reveals that foreign-born elderly individuals are more likely than their native-born counterparts to report problems with mobility and instrumental (social) activities of daily living (Rosow and SADL). The greater difficulty with social functioning among foreign-born individuals is accounted for largely by the problems they encounter with driving or obtaining transportation, areas in which the foreign-born are clearly handicapped. These data indicate, therefore, that the foreign-born are at a clear socioeconomic disadvantage and are handicapped in terms of their ability to get around. These disadvantages almost certainly increase their reliance on family.

There has been a great deal of speculation as to what accounts for the tendency of older Mexican Americans to live with their children. Our data allow us to go beyond speculation and examine responses to questions concerning preferences in current living arrangements and where one would care to live

in the event of seriously diminished health. The first response we examined was one to a question concerning why those older individuals who live with their children choose to do so. The responses to this question for married and unmarried native-born and foreign-born respondents are presented in Table 3, separately for men and women. A respondent could have chosen more than one reason, so the proportions do not add to 100%, therefore we do not present tests of significance. This table reveals that a larger proportion of foreign-born than native-born men and women who live with their children say that they live with them because both parties want it that way. Again, this difference between the native- and the foreign-born reveals a more traditional orientation toward the family and the duties of children to aging parents among the foreign-born.

The data also show that a larger fraction of foreign-born than native-born men and women live with their children because the parents provide their adult children with financial or child care assistance. On the other hand, a significantly smaller fraction of foreign-born than native-born men and women report that they live with children, or rather that their children live with them, because they are the head of household (37.3% vs 51.4% and 17.8% vs 45.3%, respectively). These data suggest, therefore, that among the foreign-born, it is more often the case that parents move in with their children than that children move in with their parents.

In order to extend this analysis, we examined responses to a question that asked respondents whether they were satisfied with their current living arrangement and if not, where they would prefer to live. The most striking finding was that only 115 individuals indicated that they were unsatisfied with their present living arrangement and would prefer to live somewhere else (data not shown). An additional 36 respondents stated that they would prefer to live somewhere else but did not specify where that might be. Of course, a question of this sort cannot elicit subtle dissatisfactions with current living arrangements and, we suspect, most people normalize their situation if, in fact, some other arrangement is unrealistic. Nonetheless, the answers to this question suggest that most individuals are quite satisfied with their current living arrangements.

In Table 4, we examine another facet of the issue and present data on where the older respondent would care to live in the event that he or she could no longer take care of him- or herself. Nearly 20% of foreign-born in comparison to 13% of native-born Mexican American couples who are currently living only with their spouse state that they would want to live with their children in the event that they could no longer take care of themselves. On the other hand, native-born elderly individuals who are living

Table 2. Sociodemographic, Health, and Disability Characteristics by Nativity Status (Weighted Percentages)

Variable	Native	Foreign
Unweighted *N*	*n* = 1,704	*n* = 1,346
Age (mean)	72.1	73.9****
Household size (mean)	2.5	3.1****
Female	56.0	57.1
Education		
None	13.7	19.5****
1–8 years	59.3	71.2
9–12 years	22.1	7.6
13 or more years	4.9	1.7
Household income		
Less than $5,000	11.8	15.2****
$5,000–9,999	35.8	40.5
$10,000–14,999	27.7	23.7
$15,000 or more	24.8	20.6
Personal income		
Less than $5,000	28.9	40.2****
$5,000–9,999	49.0	47.7
$10,000–14,999	14.2	8.7
$15,000 or more	7.9	3.4
Disability		
PADL[a]	13.2	16.4
SADL[b]	33.8	51.1****
Rosow[c]	38.9	49.0****
Poor health[d]	50.4	52.8

[a]Percent who need help with at least one physical activity of daily living (PADL).

[b]Percent who need help with at least one social activity of daily living (SADL).

[c]Percent who need help with heavy housework, walking up/down stairs, and/or walking half of a mile (Rosow).

[d]Self-assessed health as either fair or poor. Differences between native and foreign born.

*$p < .05$; **$p < .01$; ***$p < .001$; ****$p < .0001$.

Table 3. Reasons for Living with Children (Weighted Percentages)

	Men		Women	
Reason for Living With Family	Native	Foreign	Native	Foreign
Unweighted *N*	*n* = 160	*n* = 168	*n* = 248	*n* = 227
Because my child wants me to live with him or her and/or it is best for everyone if parents live with their children	33.8	50.5	42.5	65.3
Because I help with child care and/or household finances	18.1	20.7	17.6	23.7
Because I have poor health	5.3	9.0	16.7	12.4
Head of household	51.4	37.3	45.3	17.8
Other[a]	3.5	12.1	8.9	12.0

[a]Other responses include "I have no where else to go"; "I am divorced"; "My child is developmentally disabled"; "My child is mentally ill"; "My child is physically disabled"; "We keep each other company"; "My child is an alcoholic"; "My married stepdaughter is my lifelong companion"; "I rent space from my child."

with only their spouse are much more likely than their foreign-born counterparts to express a desire to enter a nursing home.

Foreign-born Mexican Americans who live with family also express a stronger desire than natives to continue living with children in the event of declining health (44.0% vs 38.1%). On the other hand, twice as many of the native-born than the foreign-born who are currently living with family chose a nursing home as an option. Regardless of their current living arrangement, then, these data indicate that in contrast to the native-born, foreign-born older persons expect to live with their children in the event of incapacity.

Our objective so far has been to shed some light on the reasons that certain older Mexican-origin individuals choose to live with their children. The data so far appear to suggest that it is because the older person, at least, wants it that way. Of course, such a response may mask some other reason, such as poverty or poor health, on the part of the elderly person. An individual who is living with his or her child because he or she cannot afford to live alone or because he or she is physically unable to care for himself or herself may well normalize the situation and report satisfaction with a situation that is really made necessary by other factors. In order to get some idea as to the extent to which this phenomenon occurs, in Table 5 we compare our three functional status measures among individuals who state various reasons for living with their children. (Recall that an individual could have given more than one reason, so he or she

Table 4. Living Arrangement Preferences in the Event of Illness by Nativity (Weighted Percentages)

	Preferred Living Arrangement in the Event of Functional Incapacity									
	Spouse		Alone		Children		Nursing Home		Other	
Current Living Arrangement	Native-born	Foreign-born	Native-born	Foreign-born	Native-born	Foreign-born	Native-born	Foreign-born	Native-born	Foreign-born
Alone Unweighted N = 540	0.1	0.3	2.3	2.8	48.8	51.4	38.9	30.8	9.8	14.7
Spouse only Unweighted N = 928	80.5	76.5	0.1	0.6	12.6	19.8	6.0	2.9	0.8	0.2
Family Unweighted N = 1,106	40.3	43.8	0.7	0.4	38.1	44.0	16.2	8.0	4.6	3.9
χ^2 =	1.55		0.33		9.11**		4.46*		0.49	

*$p < .05$; **$p < .01$.

Table 5. Health Status by Reason Living with Children (Weighted Percentages)

	Men							
	Native				Foreign			
	PADL	SADL	Rosow	Poor Health	PADL	SADL	Rosow	Poor Health
Unweighted N	(160)				(168)			
Reason:[a]								
Desire[b]	12.6	18.1	44.7	46.5	14.3	33.2	25.9	60.3
Child care/Income	0.0	24.4	38.2	58.2	16.1	21.4	13.8	66.7
Health	36.9	61.0	62.2	75.9	12.8	41.0	20.7	45.5
Headship	1.1	15.9	17.4	61.0	17.6	29.1	25.7	54.8
Other	29.8	17.9	53.6	46.5	11.3	17.0	34.6	58.6
	Women							
	Native				Foreign			
	PADL	SADL	Rosow	Poor Health	PADL	SADL	Rosow	Poor Health
Unweighted N	(248)				(227)			
Reason:[a]								
Desire[b]	10.4	35.2	42.6	62.2	7.5	64.5	44.4	60.0
Child care/Income	5.4	50.0	44.2	64.0	8.6	53.5	51.2	61.5
Health	26.7	58.6	69.5	79.4	21.8	52.1	43.2	67.7
Headship	10.9	38.4	40.1	69.0	11.8	56.3	47.4	66.4
Other	16.9	35.6	45.2	55.3	10.6	51.7	60.2	83.8

[a]Stated reason for living with family.

[b]Responses include (1) their children want them to live there or (2) it's best if parents live with their children.

might have said that health was a reason, but also have stated that they prefer it that way.)

As one would expect, a large proportion of both the native- and the foreign-born who cite health as a reason for living with family have problems with physical activities of daily living and with SADLs. Yet, interestingly, a substantial fraction of those who cite desire as a reason for living with children also suffer from functional limitations and poor health, as do those who state some other reason. These data at least suggest that among Mexican American elders, living with one's child is a culturally legitimate way of coping with poor health. Among older Mexican Americans who state that they want to live with family, culturally based values may interact with necessity to determine living arrangements.

Our next and final step in the analysis is to examine living arrangements in a multivariate framework in order to determine whether other demographic factors, either economic need or health, are significant determinants of living arrangements for the native and foreign born. In Table 6, we present four logistic regression models that assess the impact of household economic status and an older person's functional status on the probability of extended living arrangements for both the native and foreign born. In Model 1 (columns one and two), we predict the likelihood of living alone versus the probability of living with others among native- and foreign-born unmarried individuals. Model 2 focuses on native- and foreign-born married individuals and assesses the probability of living with only one's spouse as opposed to living with one's spouse and children. In these models, we control for various socioeconomic and other risk factors, including age, sex, education, household income, and the functional status variables. These models also include a global health rating.

Model 1 reveals no clear independent effect of disability, i.e., PADLs or mobility (Rosow), on the probability that a single person lives alone or with others. In contrast, this model reveals that low income is associated with an increased probability of living alone, regardless of nativity status. Almost by definition, those who live alone have lower household incomes than those who live with others. Joint living arrangements, therefore, serve to increase an older person's economic status. Model 2, which focuses on married individuals, reveals that for both the native and foreign born, those individuals who live with their spouse only have lower family incomes than those who live with their spouse and others. Again, as in the case of single individuals, net of income and functional status measures have no statistically significant effect on the probability of living with others. For both single individuals and couples, therefore, living with children increases overall economic welfare. It also appears that functional incapacity is not an overriding factor in determining extended living arrangements among older Mexican Americans. However, as these data and previous studies show, it is clear that for older persons, health and economic need are interrelated (see Burr & Mutchler, 1992).

Discussion

If behavior is an indicator of preference, most older people prefer to live with their spouse while he or she is alive and alone or with family members after the spouse dies. Our data also show that in the event of incapacity, many older Mexican Americans, and especially the more traditionally oriented, foreign-born among them, living with their children is a desirable alternative. Only a minority of our respondents expressed the desire to enter a nursing home in the event of incapacity, although among those who live alone, approximately one third stated that they would choose a nursing home in the event of incapacity, perhaps reflecting the lack of an alternative.

Future long-term care policy should make use of these potential family resources and optimize the family's options for the care of their infirm elderly parents. We certainly do not advocate forcing older parents onto unwilling children. Rather, we advocate the effective use of culturally based options that increase the choices available to elderly men and women and their families. Such options would involve formal systems that complement, rather than replace, the family as the main source of long-term care for older persons. If the objective of long-term care policy is to optimize well-being while containing costs, we must take individual and family preferences into account (Wiener, Hanley, & Illston, 1992).

Our data suggest that a more traditional cultural orientation, measured in terms of nativity, is associated with a greater reliance on family, and perhaps with norms and values that dictate that older parents should rely on their children for instrumental if not necessarily financial assistance. The data also suggest that among native-born individuals, these norms and values may be weakened, although they do not disappear. As among other groups, the family remains the main source of instrumental support for older Mexican Americans, and policies that weaken the commitment of one generation to the next should be avoided.

Even for groups such as Mexican Americans who have traditionally been portrayed as familistic, though, social change and cultural and structural assimilation take their toll on family life. For Mexican Americans, as for everyone else, economic constraints limit options in living arrangements, and the necessity for women to work limits their availability as full-time caregivers for older parents. It is also clear that the motivations for extended living arrangements are complex and that the needs and desires of everyone involved play a role. In our sample, a significant number of older Mexican Americans took their children into their households because of the children's needs. In 1982, Angel and Tienda posed the question as to whether extended living arrangements represent a response to poverty or whether they reflect a cultural orientation. They concluded that both sets of factors play a role. These newer data suggest that this is still the case among the elderly and their families.

Our findings carry certain implications for public

Table 6. Logistic Regressions of Living Arrangements on Sociodemographics, Household Income, and Health, Regression Coefficients (*SE* in parentheses)

	Unmarried Live alone vs live with others		Married Live with spouse only vs live with others	
	Model 1		Model 2	
	Native n = 723	Foreign n = 630	Native n = 978	Foreign n = 715
Age				
(Reference: 65–69)				
70–74	.10	.22	.15	.09
	(.21)	(.29)	(.16)	(.20)
75–79	.20	.47	.37	.31
	(.25)	(.30)	(.21)	(.24)
80+	.47	.32	.34	.86**
	(.25)	(.28)	(.27)	(.27)
Female	−.61**	−.04	.22	.37*
	(.19)	(.24)	(.14)	(.17)
Education				
(Reference: 13 or more years)				
No school	−1.17*	.34	−1.16***	−.97
	(.50)	(.50)	(.35)	(.54)
1–8 years	−.86**	.69	−.80**	−.29
	(.47)	(.46)	(.30)	(.51)
9–12 years	−.87	1.24*	−.61	.55
	(.50)	(.61)	(.32)	(.60)
Household Income				
(Reference: $15,000+)				
$1–4,999	2.14****	2.45****	.50	.71**
	(.28)	(.31)	(.28)	(.27)
$5,000–9,999	1.86****	2.96****	.96****	1.29****
	(.24)	(.28)	(.19)	(.22)
$10,000–14,999	.53	.48	.53**	.36
	(.30)	(.40)	(.17)	(.23)
PADL (1 = one or more)	−.34	.03	−.11	−.47
	(.25)	(.28)	(.24)	(.27)
SADL (1 = one or more)	−.41*	−.39	−.18	−.11
	(.21)	(.24)	(.19)	(.20)
Rosow (1 = one or more)	−0.01	−.39	−.16	.59**
	(.20)	(.25)	(.18)	(.20)
Poor health (1 = fair or poor)	.16	.41*	−.11	−.02
	(.17)	(.20)	(.14)	(.16)
(Reference: good or excellent)				

Model 1 Native, χ^2 = 127.35**** (df = 14), Model 1 Foreign, χ^2 = 212.8**** (df = 14), Model 2 Native, χ^2 = 41.5**** (df = 14), Model 2 Foreign, χ^2 = 83.9**** (df = 14).

*$p < .05$; **$p < .01$; ***$p < .001$; ****$p < .0001$.

policy toward the long-term care of the elderly. The objective of such policy is to provide the highest quality health care and community support at a reasonable cost (National Academy on Aging, 1994). Ideally, we wish to allow people to remain in their homes and in the community for as long as they are able. Institutionalization is an option of last resort, and one which most individuals and families resist until there is no longer a choice. If it were possible to maintain even a fraction of the elderly in the community for longer periods at a reasonable cost, the payoff in terms of quality of life alone might well be worth the expense. In order to reach this objective, however, a better understanding of the family and living situations of the elderly, as well as their preferences, is necessary. We must also begin to identify the health resource needs of local communities if we as a society are to help provide effective services to the elderly.

The optimal use of culturally specific family and community resources for the care of the elderly may in the future become a central goal of health care policy (Torres-Gil & Fielder, 1986–87). In certain areas, especially those currently lacking basic primary care and mental health services, the barriers that impede the introduction of more efficient health care delivery and formal support systems will be formidable (Yeatts, Crow, & Folts, 1992). Although efficient mechanisms for financing and organizing health care delivery to underserved areas have not

yet been fully developed, there is reason for at least modest optimism that such mechanisms can be developed. Although we have no hard data, there is enough anecdotal experience with outreach programs that make use of nurse practitioners and other health care professionals, as well as primary care physicians who are familiar with the culture of the clientele they serve, to suggest useful avenues to pursue in developing effective health care delivery systems. Many of these involve the patient's family.

Providing care to poor older individuals in urban areas presents us with an entirely different set of issues. The availability of kin and formal community support mechanisms differs greatly between the inner city and more rural areas. In recent years, we have become increasingly aware of the role of the family in the care of the chronically ill, whether they be the chronically physically ill, the severely and persistently mentally ill, or the infirm elderly. Given the economic and social stresses that many families must endure, their commitment to care for needy family members is admirable and should be augmented by formal services designed to ease the burden of care and to improve the quality of life for all involved. The accomplishment of this goal will require a much more sophisticated understanding of the potential role of families and the constraints that they face in the care of their elderly members.

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