

# Today's Research on Aging

PROGRAM AND POLICY IMPLICATIONS

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## Elderly Immigrants in the United States

In 2010, more than one in eight (11.9 percent) U.S. adults ages 65 and older were foreign born, a share that is expected to continue to grow. The U.S. elderly immigrant population rose from 2.7 million in 1990 to 4.6 million in 2010, a 70 percent increase in 20 years (see Figure 1). This newsletter highlights recent studies of older immigrants in the United States, conducted by National Institute on Aging (NIA)-supported researchers and others.

Elderly immigrants are a diverse group, from a wide range of life circumstances. Some are highly trained professionals who immigrated early in their careers; others are the recently arrived elderly parents of naturalized citizens; and some immigrated with their families when they were young children. Understanding both the unique characteristics of elderly foreign-born adults and the challenges some of them face is important as policymakers and planners address the well-being and health of the United States' aging population.

### Demographic Trends

Fueling the growth of the U.S. immigrant population ages 65 and older are two trends—the aging of the long-term

foreign-born population and the recent migration of older adults as part of family reunification and refugee admissions (Leach 2009). This ongoing migration makes projecting the future size of the elderly immigrant population challenging. One projection estimated that the number of U.S. immigrants ages 65 and older will quadruple to more than 16 million by 2050 (Treas and Batalova 2007, cited in Leach 2009).

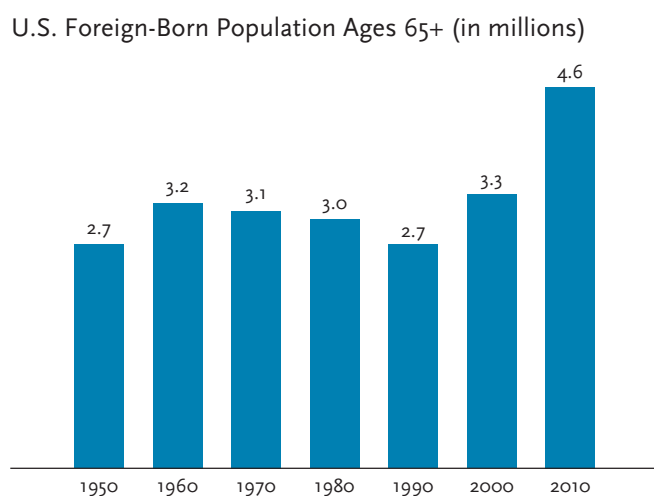
Latin America has replaced Europe as the leading birthplace of America's older immigrants. In 2010, a larger share of older foreign-born adults were of Latin American origin (38 percent) than of Asian (29 percent) or European (28 percent) origins (Wilmoth 2012). In 2010, a majority of immigrants ages 65 and older (60 percent) had entered the United States before 1970. Analysis of American Community Survey data suggests that 10 percent of immigrants ages 65 and older had been in the country fewer than 10 years in 2010 (Batalova 2012).

#### In This Issue

- Demographic Trends
- Economic Circumstances
- Anticipating the Aging of the Immigrant Baby-Boom Generation
- Living Arrangements
- Life Expectancy and Health
- Health Care Use of Europe's Immigrants
- Disability

This publication summarizes research related to the objectives of the National Institute on Aging, with emphasis on work conducted at the NIA demography centers. Our objective is to provide decisionmakers in government, business, and nongovernmental organizations with up-to-date scientific evidence relevant to policy debates and program design. These newsletters can be accessed at [www.prb.org/TodaysResearch.aspx](http://www.prb.org/TodaysResearch.aspx)

**Figure 1**  
The U.S. foreign-born population ages 65 and older increased substantially between 1990 and 2010.



**Sources:** U.S. Census Bureau, historical census data 1950-2000, and Current Population Survey, 2010.

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Most U.S. immigrants who settle in this country after age 60 are sponsored by their adult children who had immigrated to the United States as young adults. Beginning in 1965, family reunification provisions in U.S. immigration policy gave naturalized U.S. citizens the opportunity to petition for their parents' entry outside the usual quota restrictions. The annual number of late-life immigrants (ages 60 and older) admitted to the United States has grown but has varied from year to year, from 40,000 in 1986 to more than 86,000 in 2010, with a high of nearly 101,000 in 2006, according to Wilmoth's (2012) analysis of Department of Homeland Security data.

Long-term immigrants who arrived as children or young adults and are "aging in place as long-standing U.S. residents" tend to face challenges similar to their U.S.-born peers (Wilmoth 2012). By contrast, immigrants who migrate after age 60 are often a "potentially vulnerable population" due to limited English language proficiency, little or no U.S. work experience, and weak ties to social institutions. They face rules barring them from participating in most entitlement and welfare programs unless they become naturalized citizens, but their language skills and age are often a barrier to naturalization. Compared to immigrants who arrive earlier in life, late-life immigrants are more likely to be female, to have low education levels, to have limitations in physical functioning, and to be widowed.

The length of time immigrants have spent in the United States is key to their acquiring English language skills, which contribute directly to their ability to use health care and other social services (Leach 2009). More than two-thirds of recent older immigrants (71 percent) did not speak English well in 2006, compared to just about one-third of long-term older immigrants (31 percent). Late-life immigrants with limited English skills must depend heavily on family members, putting them at risk of isolation and depression (Wilmoth 2012).

Recent older immigrants are more likely than long-standing immigrants to settle outside traditional destination cities, such as New York, Los Angeles, and Miami (Leach 2009). Late-life immigrants are contributing to growing immigrant populations in rural areas and small towns in midwestern and southern states, including Minnesota, Kansas, Georgia, and North Carolina. English proficiency is particularly important for functioning in rural areas; bilingual staff in health care settings, senior service agencies, and legal aid organizations are rare in many places (Gurak and Kritz 2013).

## Economic Circumstances

Foreign-born elderly tend to have less personal income than U.S.-born elderly, on average. But overall, by any number of measures, family or household income (unadjusted for household size) is higher for the foreign-born elderly than for the U.S.-born elderly. This likely reflects both the living arrangements of the elderly immigrants and higher levels of labor force participation for elderly immigrant men who have been in the United States for fewer than 10 years. Extended-family living, more common among immigrant groups, tends to boost household income because multiple earners are often present. In addition, family income captures not just the income of the elderly person but also, for dependent elderly, income of other family members. Similarly, household income captures income from all persons at the same address.

National averages mask wide differences by country of origin. One study that examined average household income in the 2006 to 2008 period for adults ages 60 and older found that certain immigrant groups had incomes substantially higher than their U.S.-born peers, including older Indian, Filipino, and Chinese immigrants (Gurak and Kritz 2013). Household income for older Mexicans was substantially lower than that of their U.S.-born peers during the period.

Borjas (2009) found that both the relative wages and skills of U.S. immigrants have declined since the 1950s, raising concerns about what economic resources immigrants will have in their old age. His analysis showed growing disparity in the average personal income of immigrants ages 65 and older and their U.S.-born counterparts. The income gap between immigrant and U.S.-born elderly widened from 5 percent in 1970 to 30 percent in 2007. A growing income gap also is evident *within* the immigrant population, with older immigrants who had lived in the United States for fewer than 10 years having far less annual income than those who had been in the United States for 10 years or longer.

Reliance on a different mix of economic resources in old age accounts for some of the income differences between immigrant and U.S.-born elderly. Borjas (2009) found that in 2007 U.S.-born elderly were considerably more likely than immigrant elderly to receive Social Security benefits, investment income, and retirement benefits such as pensions. These differences may be a result of the high proportion of immigrants originating from less economically developed countries. These immigrants tend to lack "human capital necessary to obtain jobs that provide pensions, may lack adequate health insurance, and often have a

## Box 1

### Anticipating the Aging of the Immigrant Baby-Boom Generation

While only 5 percent of non-Hispanic white baby boomers (ages 49 to 67 in 2013) were foreign-born in 2006, immigrants made up about two-thirds or more of both Hispanic baby boomers and Asian baby boomers (Mutchler and Burr 2009, cited in Gerst and Burr 2012). The aging of the baby-boom generation will contribute to a shift in national origin of elderly immigrants from European to Asian and Latin American, with implications for economic well-being and public assistance spending. Foreign-born Asian and Hispanic baby boomers have saved less for retirement than U.S.-born non-Hispanic white baby boomers (Hao 2007, cited in Gerst and Burr 2012). One recent analysis suggests that when immigrants ages 40 to 55 in 2007 reach age 65, the share of immigrants with investment income will decline from 20 percent to 14 percent, and the share receiving public assistance will rise from 13.1 percent to 14.6 percent (Borjas 2009).

Wage trends and assimilation patterns suggest that the income gap between immigrant and U.S.-born elderly may continue to widen as the baby-boom generation ages (Borjas 2013). Analysis of Census data from 1970 to 2010 shows that immigrants who settled in the United States during the 1960s and 1970s had higher relative wages on entry than more recent immigrants. Additionally, the wage gap between pre-1980 immigrants and U.S.-born workers tended to narrow much more quickly than it has for more recent immigrants. Immigrants who entered the United States in the 1990s, for example, have seen this wage difference change little since their arrival.

Borjas (2013) suggested that a portion of the slowdown in immigrants' wages relative to U.S.-born workers can be

explained by a decline in developing the skills that can make them "marketable in [their] new economic setting." Specifically, the rate at which the newer immigrants acquire English language skills declined at the same time as wage gains declined. English proficiency grew slowest for immigrants from countries with large groups already represented in the U.S. population, such as Mexico and China. "Immigrants who find relatively few of their compatriots living in the United States typically have a stronger incentive to make the U.S.-specific investments that will allow a wider range of social and economic exchanges," Borjas speculated. "In contrast, immigrants who enter the country and find a large welcoming ethnic enclave have much less incentive to engage in these types of investments since they will find a large market for their pre-existing skills."

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harder time accumulating resources for retirement" (Gerst and Burr 2012).

Immigrant elderly were more likely to be employed than U.S.-born elderly (30 percent versus 18 percent in 2007) (Borjas 2009). Gerst and Burr (2012) suggested this reliance on earned income "implies a heavier dependency on continued employment in later life." The need to continue working makes the economic well-being of immigrant elderly more vulnerable to labor market fluctuations and health problems than if they had greater access to pensions and Social Security benefits.

Older immigrants' higher employment rates are driven in part by incentives related to Social Security program eligibility (Borjas 2011). Analysis of 30 years of Census data (1970-2000) shows that as retirement age approaches, the employment rate of foreign-born men declines more slowly

than that of U.S.-born men. Before their late 50s, foreign-born men tend to have lower employment rates than U.S.-born men, but after their early 60s immigrant males tend to have higher employment rates. This "crossover point" is related to Social Security benefit eligibility rules that require workers to be employed for at least 10 years in the United States. Once the 10-year minimum is met, foreign-born workers tend to retire. By age 70, U.S.-born and immigrant men have similar labor force participation rates. The retirement of recently arrived elderly immigrant men will contribute to already rising Social Security program costs.

A preliminary study of Social Security beneficiaries found that about 10 percent of Latin American immigrants born between 1915 and 1918 returned to Latin America to live (Vega 2013). Lower Social Security benefits do not appear to increase the likelihood of Latin American immigrants

returning to their country of origin. Latin American-born immigrants with lower benefit levels due to miscalculation of benefits had similar migration patterns as other Latin American immigrants. Poverty and few or no retirement benefits, however, may contribute to return migration (Vega 2013; Van Hook and Zhang 2011, cited in Vega 2013).

Immigrant elderly also receive public assistance at more than twice the rate of U.S.-born elderly (13 percent versus 5 percent in 2007) (Borjas 2009). Virtually all of the older immigrants' public assistance income came through the Supplemental Security Income (SSI) program—a federal program providing supplemental payments to elderly, blind, and disabled people who have little or no income—suggesting that a sizeable share of immigrant elderly have extremely limited economic resources. Gerst and Burr (2012) found that 11 percent of elderly Asian immigrants and 15 percent of elderly Hispanic immigrants were receiving SSI, based on 2006 to 2010 American Community Survey data. The 1996 welfare reform law restricts the use of federal welfare programs, preventing most legal permanent noncitizen residents from receiving SSI benefits. Naturalized immigrants do not face the same restrictions. If more of the elderly foreign-born were to become naturalized citizens, the share of elderly immigrants receiving SSI would likely be higher.

Not surprisingly, immigrant elderly were more likely to have incomes below the poverty line than U.S.-born elderly. In 2010, 8 percent of U.S.-born elderly lived below the poverty threshold, compared to 16 percent of foreign-born elderly (U.S. Census Bureau 2012; see Figure 2). The U.S. Census Bureau (2012) estimates that within the foreign-born elderly population, 15 percent of older Asian immigrants, 21 percent of all older Hispanic immigrants, and 23 percent of older Mexican immigrants lived below the poverty line in 2010. Poverty is also related to citizenship status: In 2010, 13 percent of elderly foreign-born naturalized citizens and 21 percent of elderly noncitizens lived below the poverty line (Wilmoth 2012). In their study of rural immigrants, Gurak and Kritz (2013) called the high rate of poverty among older foreign-born Mexicans “worrisome” given the large share of total U.S. immigrants they represent.

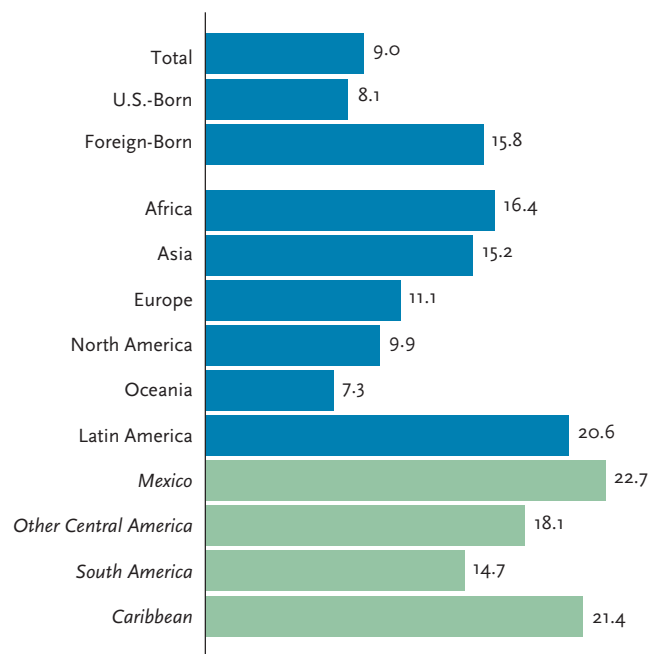
Another measure of economic need is participation in the Supplemental Nutrition Assistance Program (SNAP). In the period 2006 to 2010, 5 percent of U.S.-born elderly lived in households participating in SNAP, while the share of elderly Hispanic immigrants was four times higher (20 percent) and the share of elderly Asian immigrants was more than twice as high (12 percent) (Gerst and Burr 2012).

## Living Arrangements

Compared with their U.S.-born peers, elderly immigrants are more likely to live in extended-family households, especially those who arrived in the United States after age 60 (Wilmoth 2001; Wilmoth, De Jong, and Himes 1997, cited in Wilmoth 2012). Older adults are usually classified as residing in an extended-family household if they live with at least one relative other than a spouse or a young child. Extended-family households often are established as a response to economic need, providing a way to conserve limited income and assets. Extended-family living may also reflect cultural preferences among some immigrant groups, “shaped by long-standing practices of filial piety” (Wilmoth 2012). Such households may be established to provide intergenerational support, such as child care, or to address “concerns about their aging relative’s health status or social isolation.” For late-life immigrants, the extended-family living arrangement may represent the support provided by the adult child who sponsored a parent’s immigration. However, Vietnamese immigrants ages 50 and older participating in focus groups expressed fear of losing independence and becoming a burden to their fami-

**Figure 2**  
Foreign-born elderly have higher poverty rates than U.S.-born elderly.

Percent of Specific Group in Poverty in the Previous 12 Months



Note: Data based on sample.

Source: U.S. Census Bureau, “The Foreign-Born Population in the United States: 2010,” *American Community Survey Reports ACS-19*, May 2012.



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lies; Chinese and Latino focus group participants (both U.S.-born and immigrant) also voiced these same worries (Laditka et al. 2011).

Levels of extended-family living vary widely among immigrant groups. In 2000, based on analysis of Asian and Hispanic immigrants ages 60 and older from 11 countries of origin, the most extended-family living occurred among Indians, Vietnamese, Filipinos, Dominicans, and Mexicans (Gurak and Kritz 2010). About 50 percent in each of these immigrant groups lived in extended families, making them roughly four times more likely to do so than U.S.-born non-Hispanic whites.

Analysis of 2000 Census data showed that older immigrants who lived in extended-family households were more likely to be unmarried, to have lower levels of education and income, and to have more disabilities than immigrants who did not (Gurak and Kritz 2010). Assimilation plays a strong role in living arrangements: Older immigrants were less likely to live in an extended-family household if they had a high level of English language proficiency, lived outside of areas where their immigrant group traditionally settled, and immigrated at younger ages. When the researchers controlled for the economic resources of older Vietnamese and Mexicans (groups that tend to have lower income levels), the difference in extended-family living compared with U.S.-born older non-Hispanic whites narrowed considerably, but not as much as when assimilation measures were taken into account. Some groups, however, tend to have high levels of both economic resources and extended-family living (such as Indians and Filipinos), suggesting that cultural preferences continue to play an important role in housing decisions.

Results of a study that focused on differences within the elderly U.S. Hispanic population in 2000 underscore the role of assimilation in influencing living arrangements (Burr, Mutchler, and Gerst 2010). Compared to elderly U.S.-born Hispanics, elderly foreign-born Hispanics in 2000 were more likely to live in crowded housing (more than one person per room) even after demographic and socioeconomic characteristics were taken into account. This study found that among elderly foreign-born Hispanics, the lower their levels of English language proficiency and the shorter the length of time they had been living in the United States, the more likely they were to live in a crowded household. Additionally, renters were more likely to live in crowded settings than owners. The researchers found no link between living in an ethnically segregated area and crowding. They did find that with all else equal (including income and the cost of housing), living in an urban area with a relatively large Hispanic population

increased the likelihood of crowding, suggesting that elderly immigrant Hispanics may place a higher value on physical proximity to other Hispanics than on larger living quarters.

**Living With and Caring for Grandchildren:** Immigrants 65 and older are much more likely than U.S.-born elderly to live with their grandchildren. In 2007, about 14 percent of immigrant elderly lived with at least one grandchild, compared with just 4 percent of the older U.S.-born elderly population (Terrazas 2009). However, among grandparents living with their grandchildren, older immigrant and U.S.-born elderly were equally likely to have primary responsibility for caring for these children.

**Nursing Home Residence:** Gurak and Kritz (2010) studied older Asian and Hispanic immigrants from 11 countries and found that they were much less likely than older U.S.-born non-Hispanic whites to reside in nursing homes, group homes, or other types of group quarters. In 2000, 5 percent of U.S.-born non-Hispanic whites ages 60 and older lived in group settings, compared to only about 1 percent of older immigrant Hispanics and Asians. Additionally, a study of older Hispanics (both immigrant and U.S.-born) in five southwestern U.S. states found those who had spent time in a skilled nursing facility were much more likely to use English as their primary language, suggesting that language assimilation plays a role in the use of institutional care (Finley et al. 2013).

## Life Expectancy and Health

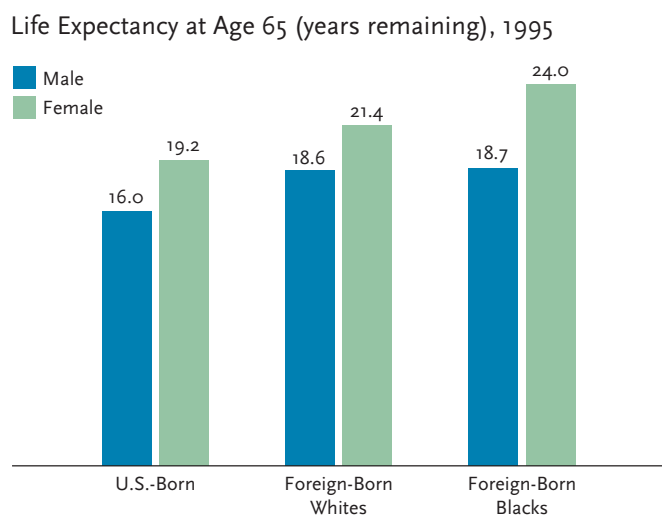
Mortality statistics show that immigrants tend to live longer than their U.S. counterparts. One recent analysis explored the magnitude of these differences. Dupre, Gu, and Vaupel (2012) examined newly available Medicare records linked to Social Security Administration files for more than 30 million Medicare-eligible U.S. elderly in 1995, the most recent year for which these data are available. Compared to Medicare-eligible U.S.-born adults, Medicare-eligible foreign-born adults had lower mortality at nearly every age between 65 and 100 (see Figure 3, page 6, for life expectancy at age 65). The study demonstrated that the U.S. foreign-born elderly population contributed to an increase in overall U.S. life expectancy. In particular, U.S. foreign-born adults “were among the longest-lived older adults in the world” when compared to older adults in other industrialized countries. Additionally, among the Medicare-eligible, foreign-born U.S. blacks had the longest life expectancy of any group examined. This “exceptional longevity” stands in “contrast to the well-documented disadvantages and correlated health risks among U.S.-born blacks.”

Better health is at the root of these life expectancy differences, and research continues to find that, overall, immigrants

tend to be healthier on arrival than their U.S.-born peers (for more information, see “The Health and Life Expectancy of the Older Blacks and Hispanics in the United States,” *Today’s Research on Aging* 28, June 2013). These health advantages include higher levels of cognitive functioning at the time of migration (Hill et al. 2012). Studies of cellular function also find evidence of better health among new immigrants (Kaestner et al. 2009). These differences reflect the “healthy migrant effect”—that is, immigrants who are able to make the trip are “healthier, wealthier, and more educated” than the compatriots they leave behind (Wilmoth 2012). Also, U.S. immigration policies give preference to immigrants with high levels of education and do not admit people with infectious diseases and other undesirable characteristics.

Once in the United States, cultural factors—such as better health habits and stronger networks of social support—may offer protection from some diseases and lead to longer lives. Immigrants often have healthier diets and smoke less than the U.S.-born population (Osypuk et al. 2009; Blue and Fenelon 2011). Some immigrant communities are characterized by high levels of family contact and mutual assistance, with religious participation playing an important role (Taylor, Chatters, and Jackson 2007; Jackson, Forsythe-Brown, and Govia 2007). But these health advantages are often reduced over time as immigrants become more assimilated and adopt more typical U.S. diets and lifestyles, particularly among

**Figure 3**  
**Foreign-born elderly tend to live longer than their U.S.-born peers.**



**Source:** Matthew Dupre, Danan Gu, and James Vaupel, “Survival Differences Among Native-Born and Foreign-Born Older Adults in the United States,” *Public Library of Science One* 7, no. 5 (2012): e37177.

immigrants with low income and education levels (Gallo et al. 2009; Lutsey et al. 2008). There is also evidence that some immigrants leave the United States to return to their birthplace when their health deteriorates, resulting in measured population health outcomes that are better than they would have been if the returning immigrants had remained in the United States (Palloni and Arias 2004; Turra and Elo 2008; Riosmena, Wong, and Palloni 2012).

Studies find that immigrant adults (ages 18 and older) have lower medical expenditures than U.S.-born adults, even among those immigrants who are fully insured (Tarraf, Miranda, and González 2012; Ku 2009). Among adults ages 65 and older, immigrants and the U.S.-born population tend to have similar levels of health care expenditures (Mohanty et al. 2005). (See Box 2, page 7, for findings on health care use among older immigrants in Europe.) Some immigrant groups’ attitudes toward cognitive decline and diseases such as Alzheimer’s may prevent them from seeking appropriate health care and taking steps to prevent loss of mental function (Laditka et al. 2011). Vietnamese immigrants ages 50 and older participating in focus groups said that cognitive loss was a normal part of aging rather than the result of a disease; Chinese and Latino participants (both U.S.-born and immigrant) also viewed mental decline as an expected part of the aging process.

## Disability

While some immigrant groups in the United States have fewer chronic diseases in old age than their U.S.-born peers, there is growing evidence that important segments of the immigrant population are reaching older ages with more physical limitations and disability than their U.S.-born counterparts (Zhang, Hayward, and Lu 2012). A study based on 2000 Census data found that older Asian immigrants face a greater likelihood of having a disability than U.S.-born non-Hispanic whites (Mutchler, Prakash, and Burr 2007). Specifically, Asian immigrants were more likely than U.S.-born elderly to have difficulty going out alone shopping or to a medical appointment and to have problems performing personal care such as dressing, bathing, and getting around the house. Elderly Vietnamese immigrants tended to have the highest disability levels, likely reflecting their arrival as refugees and limited economic resources. One study of foreign-born Hispanic men found that their disability levels rose steeply after age 50, making them more likely to be disabled than non-Hispanic white men between the ages of 50 and 75 (Hayward et al. 2011). While foreign-born Hispanic men may have been healthier than average at the

## Box 2 Health Care Use of Europe's Immigrants

Immigrants ages 50 and older residing in European countries tend to be less healthy than their European-born peers and tend to use more health care services, based on survey results from 11 European countries (Solé-Auró and Crimmins 2008; Solé-Auró, Guillén, and Crimmins 2012). After taking into account demographic characteristics, the researchers found that older immigrants in Europe used between 13 percent and 20 percent more medical care than their European-born counterparts, both across the entire sample and in some individual countries.

Immigrants had more physician visits and hospital stays than the European-born population, even after the researchers controlled for differences in health, socioeconomic status, health care access, and payment sources. However, the gap between the two groups narrowed when researchers took into account health status. This finding suggests that “the worse health of immigrants plays a role in their higher usage.” Immigrants’ poorer health explained about half of the difference in their use of physician services but not of hospitals.

The studies were based on the Survey of Health, Ageing and Retirement in Europe (SHARE), which provides comparable data for individuals in 11 countries (Austria, Belgium, Denmark, France, Germany, Greece, Italy, Netherlands, Spain, Sweden, and Switzerland). The nationally representative set of respondents were living in community settings. For this study, immigrants were defined as people living in a country other than their birthplace, regardless of citizenship.

Recent immigrants were more likely to have high health care usage than immigrants who had lived in Europe for longer periods. The researchers found that immigrants tended to use more physician services in countries with greater relative expenditures on health care, higher physician density per capita, and fee-for-service payments to physicians.

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start, manual labor likely took a physical toll that became evident later in life, the authors suggested.

Gurak and Kritz’s (2013) study of older rural immigrants found that all major groups examined except Mexicans were less disabled and had fewer health limitations than the U.S.-born rural population in both 2000 and 2008. Older rural Mexicans immigrants, however, had almost twice as many limitations as other immigrant groups. Another study based on 2006 American Community Survey data found that one in four Mexican immigrants ages 55 and older had functional limitations (any long-term condition limiting walking, climbing stairs, reaching, lifting, or carrying), a disability level the researchers called “disturbingly high” (Thomson et al. 2013). In addition, among Mexican immigrants, the longer they had lived in the United States, the more likely they were to have a problem with physical functioning. When the researchers took into account education and income, however, they found that Mexican immigrants were less likely to have limitations in physical function than U.S.-born non-Hispanic whites. Finally, limited English language proficiency appears linked to high levels of physical limitations. Findings from these studies suggest that older Mexican immigrants have high levels of health care needs, driven in part by low socioeconomic status and manual labor, and that

this group could benefit from bilingual health care service providers and preventive care.

## Conclusion

The growing share of foreign-born elderly in the U.S. population faces greater economic challenges than the U.S.-born elderly population, on average, but they may also have some advantages in terms of longevity and social networks. Findings with respect to longevity suggest that the immigrants live longer, but this is balanced by high rates of disability among some segments of the foreign-born elderly. Low personal income and laws restricting noncitizen access to federal programs may prevent some immigrants from seeking preventive care. Limited English language skills of both the elderly and their caregivers may be an additional barrier to health services, particularly institutional services. Better transportation and more accessible community health services could help low-income immigrant elderly “age in place” in their communities as they say they prefer, saving human service costs and improving quality of life (Vega and González 2012). It remains unclear whether immigrant living and caregiving arrangements are the result of preferences or barriers to accessing services.

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## The NIA Demography Centers

The National Institute on Aging supports 14 research centers on the demography and economics of aging, based at the University of California at Berkeley, University of Chicago, Duke University, Harvard University, Johns Hopkins University, University of Michigan, National Bureau of Economic Research, University of Pennsylvania, Princeton University, RAND Corporation, Stanford University, Syracuse University, University of Southern California/University of California at Los Angeles, and University of Wisconsin-Madison.

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