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GEE ET AL. RESPOND

Many studies use self-reported language measures.[1–3] We cautioned against conflating English proficiency and language preference.[4] We thank Ayers for confirming that English proficiency is related to self-rated health, regardless of whether proficiency is measured via self-report or interviewer assessment.

Ayers' main point is that objective indicators of proficiency are more accurate than self-report indicators,[2] a point we made in our paper.[4(p568)] Ayers argues that interviewer assessments should have been used as the measure of English proficiency because it is "objective" and face valid. As members of the team who collected the data, however, we caution against overstating these assessments. National Latino and Asian American Study (NLAAS) interviewers were well-trained, but they were not trained to assess English proficiency for research purposes. Hence, interviewer assessments have unknown biases.

Ayers' analysis of language preference differs from ours. We find that preference is inconsistently associated with self-rated health. Ayers claims this inconsistency is spurious, resulting from our inclusion of survey language. After removing survey language, he finds that preference measures are associated with self-rated health. He assumes that survey language measures preference.

We made a different assumption. We included survey language to control for instrumentation bias related to translation. Although NLAAS uses state-of-the-art translation methods, translations may still be nonequivalent. There is no "correct" assumption here, although if anything, our assumption made our analyses too conservative.

Nevertheless, our conclusions were derived after modeling binary and ordinal measures of self-rated health; Ayers considers only the latter. Table 1 replicates our study by modeling binary and ordinal measures of self-rated health, omitting survey language. Our ordinal analyses are consistent with Ayers', yet the binary analysis show that preference is not consistently related to self-rated health. Accordingly, a complete replication supports our original findings.

Moreover, one must not just analyze data, but also interpret it. The "unilinear" acculturation perspective predicts a gradient, with bilingual respondents falling intermediate between English and Asian speakers. In Ayers' Figure 1, the finding for language preference with friends is consistent with the unilinear perspective, but language of thinking or with friends is not. English speakers are not significantly different from non-English speakers. The only difference is between bilingual and non-English speakers. Ayers does not provide a substantive interpretation for these inconsistencies, but very similar results are discussed in our original article.[4(p567)]

We hope that researchers evaluate the central question of whether proficiency is equivalent to preference. Adding alternative

TABLE 1—Reanalysis of English Proficiency and Language Preference Measures: National Latino and Asian American Study, 2002–2003

	Binary Self-Rated Health, b (SE)	Ordinal Self-Rated Health, b (SE)
Language preference (continuous)		
When thinking	−0.139 (0.083)	−0.155** (0.056)
With family	−0.002 (0.091)	−0.035 (0.076)
With friends	−0.245* (0.093)	−0.190** (0.069)
Language preference when thinking (categorical)		
Asian language (Ref)	1.00	1.00
Both languages	−0.597** (0.199)	−0.582*** (0.154)
English	−0.302 (0.226)	−0.362* (0.176)
Language preference when speaking with family (categorical)		
Asian language (Ref)	1.00	1.00
Both languages	−0.269 (0.252)	−0.543* (0.209)
English	−0.002 (0.337)	0.018 (0.239)
Language preference when speaking with friends (categorical)		
Asian language (Ref)	1.00	1.00
Both languages	−0.794*** (0.204)	−0.535** (0.164)
English	−0.568* (0.233)	−0.496** (0.177)
Language preference scale	−0.175 (0.110)	−0.174* (0.079)
Combined scale	−0.592*** (0.132)	−0.493*** (0.082)

Note. Analyses are similar to Table 3 of Gee et al.,[4] except that survey language is not controlled. The sample size was n = 1639.

measures does not resolve the larger theoretical issues. ■

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DATA ON DISABILITY

Seeman et. al.'s enlightening article[1] concludes that older Americans face increased disability. This increase, revealed by data from the National Health and Nutrition Examination Surveys, particularly affected adults aged 60–69 years, with no significant trends among adults aged 70–79 years, and a lower prevalence among those aged 80 years and older. These findings are confirmed by another survey series, the National Mortality Followback Surveys of 1986 and 1993, conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention.[2,3]

The National Mortality Followback Surveys made inquiries of the next of kin of a representative sample of all adult decedents in the United States in 1986 and 1993. Questions were asked as to whether the decedent needed help or used special equipment in walking, eating, bathing, dressing, or using the toilet (Table 1). On all but the last of these questions about activities of daily life, the affirmative responses regarding adults aged 65–74 were greater in 1993 than they were in 1986. Among those aged 75–84 years, no such trend was observed. Among those aged 85 years and older there was a decrease in disability.

The observation by Seeman et. al. that their conclusions have significant and sobering implications for the US health care system and health care costs is strengthened by these confirming findings in another series of national surveys. ■

TABLE 1—Percentage of Adults With Affirmative Response to Questions on Needing Help With Activities of Daily Life: National Mortality Followback Survey, 1986 and 1993

	Age 65-74 Years			Age 75-84 Years			Age 85 Years and Older		
Function	1986, %	1993, %	% Difference[a]	1986, %	1993, %	% Difference[a]	1986, %	1993, %	% Difference[a]
Walking	44.5	59.4	14.9	54.9	59.9	5.0	71.6	68.4	−3.2
Eating	31.4	35.5	3.9	37.3	49.7	3.6	49.7	40.4	−9.3
Bathing	50.8	53.0	2.2	60.6	58.2	−2.4	79.1	71.0	−8.1
Dressing	45.0	46.6	1.6	53.5	50.3	−3.2	68.7	61.5	−7.2
Use of toilet	44.9	44.6	−0.3	53.2	47.3	−5.9	67.2	58.0	−9.2

[a]Statistically significant at the 95% confidence level.

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