Gender Differences In Elder Mexican Adults and Access to Healthcare

Abstract

Gender differences in health have always been an interesting topic of discussion. Women have always outlived men, but complained of more pain. Throughout many studies, we see that many females have reported more limitations in healthcare and physically diminished faster than men (Murtagh and Hubert, 2004). These differences can additionally be seen in older Mexican groups as well. This paper will discuss the health differences between men and women in older Mexican adults. Furthermore, it will show evidence that women do not have equal access to men like women do. While the underlying force for most women is disability-related health conditions, for Mexicans the main differences in chronic disease can be attributed to citizenship status, relationships with ADL's, and divisional differences. Include results...demographics…. and what it means… accessibility of health

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Health services is a growing sector of our economy and among one of the largest in society. It is vital that each group has equal access to these benefits. Unfortunately, that is not the case for a lot of older adults. While most elderly people have some type of access to Medicaid, it is often accompanied with expensive burdens that make it hard to keep the long-term care that they need. Additionally, American's ranked healthcare as the second most biggest problem that needs to be addressed with the government (Drainoni et al., 2006). This finding is very telling in that it is not a problem that researchers are only looking into, but also normal civilians in America.

Additionally, the backbone of every healthcare system is the government that supports it. Subsequently, health beliefs coincide with cultural norms and values and can explain how social structures can affect perceived needs (Aroian, Tran & Wu, 2005). This can limit certain ethnic groups from receiving the healthcare that is necessary and their approaches to healthcare may be minimized because a culture may not understand why they need certain accommodations. Another problem in health care is purely based on the availability of physicians. For example, Sammartin and Ross (2006) found that fifteen percent of Canadians had trouble accessing healthcare and 23% reported difficulties with finding immediate care. Women reported more troubles accessing both types of healthcare and new immigrants had the most trouble accessing immediate healthcare out of all groups. While lower class citizens actually had an easier time accessing healthcare, there should be no differences based on demographic factors. Another example showed Chinese elder immigrants experienced difficulty with healthcare in America due to language barriers, wait times, distrust in Western medicine and cultural values and norms (Aroian, Wu & Tran, 2005). This poses major issues within the healthcare system in America. The healthcare model that is used in America does not include crucial constructs such as language and culture (Portes, Kyle & Eaton, 1995). This not only affects minority racial groups in America but makes it substantially harder for immigrants to get

access to the healthcare they need.

One group that is especially limited in regards to healthcare is Mexican immigrants. Mexican Americans experience many things that lead them to have trouble with health care. One reason is a combination of jobs that do not provide strong health benefits and also the average salary limits Mexican immigrants from utilizing healthcare correctly leaving them with financial barriers to deal with. This is not only limited to elders but also to regular citizens and children who are citizens (Riedel 1998). Mexican elders in America not only have to consider the stresses of fitting into a different culture, but also have to deal with finding healthcare to fit their needs and prevent health from getting worse. Some issues, like language barriers are also a problem for Mexican immigrants. Ponce et al. (2006), stated that one way to help increase overall access to healthcare is to provide language assistance which would help reduce language barriers and make it easier for people to access medical aid.

Additionally, Groman et al. (2008) discusses the hardships that immigrant women face that lead to trouble accessing healthcare. Resettlement is a stressful process for women given high poverty rates, low wages, along with the threat of men asserting their status with violence or other forms control. Men in most ethnicities and cultures have more power than women and while that is unfortunately a flaw in today's society, it is something that women have to battle constantly. These differences debilitate immigrant women from excelling in their careers and is detrimental to not only their physical health but mental health. Also, the paper discussed that men have more access to women because there is a gender gap that exists even in the least acculturated groups. Mexican immigrants hold similar social status, however the gap still remains and it shows in pay, education, and healthcare.

While some studies (Wong and Diaz, 2007) show that women use healthcare more than men, this doesn't exclude the fact that they have more trouble accessing it. Within immigrant communities, there is still this idea of socioeconomic hierarchy and one of these include men being more powerful than women. While there is plenty literature on women using healthcare more than men, mainly because they have more chronic disease, there is only minimal literature on how women have less access to help for ADL's.

In this paper, one goal is to analyze the gender differences in access to healthcare and the help each group needs with ADL's in elder Mexican adults. ADL's are Activities Daily Lives and are defined as tasks that allow a person to survive comfortably. These include things like mobility, toilet and bathing, personal hygiene, and feeding. While IADLs, which are Instrumental Activity of Daily Lives, are important, they are not necessary for survival. They include tasks such as meal preparation, housekeeping and transportation.Vengas et al. (2015), proposed one solution to this problem. While many older Mexican adults are interdependent because of healthcare-related issues, this can actually be reversed. By separating ADL's and IADL's, it can reduce the differences between men and women. By separating the two, the healthcare system can provide an adequate and effective plan to make it easier to access for everyone.

Additionally, this paper investigates the healthcare system in the United States, why Mexican women immigrants have a harder time accessing healthcare, and how the system can be fixed to provide adequate healthcare for all. While there has been a lot of research regarding gender differences in healthcare there has never been research examining the population of female immigrants. This is important to discuss because immigrants are frowned upon by so many citizens, they at least deserve the backing of the US government. Especially women who are

already struggling in a male dominant society it is important to shed lights on these issues. While searching for some answers to these problems the MHAS dataset was used.

The MHAS data set is a longitudinal study that examines 50 years and older in Mexico. It consists of several measures that were drawn from urban/rural population. The data set consists of several different researchers from University of Texas Medical Branch (UTMB), the Instituto Nacional de Estadística y Geografía (INEGI, Mexico), and many more institutions. In the sample there were over 14,000 respondents. The specific variables that are examined in the paper had 1,100 respondents. We analyzed the gender differences in males and females and which group had access to ADL's compared to the other. We hypothesized that women would have less access to healthcare than men. This prediction came about because men have more power than female, as well as social status. Though both groups are minorities and face similar struggles immigrating to American, it does not eliminate gender differences. It is important to find why this is happening and fix a potential flaw in America's healthcare system.

Method

Participants

The 14,779 participants in this study were from the Mexican adult population. They all voluntarily agreed to participate in this experiment. The study consisted of 6,142 males and 8,637 females. While looking at the specific variables measured, 372 males answered and 725 women answered about access to ADL's with a total N=1,097 participants. For the purpose of the results, participants under the age of 50 were left out of the analyses. Subsequently, the participant's ages ranged from 50 to 104 years old with a mean range of 67 years old. The means of compensation were not explicitly stated.

Procedure

The data that was collected comes from the third wave of the Mexican Health and Aging Study (MHAS 2012). Collected from adults who were born prior to 1951, this study is nationally representative of the Mexican adult population as it includes participants from urban and rural areas from 31 states in Mexico and the US. The information was collected through in person interviews and discussed topics that included status, migration history, health status, intergenerational transfers and socioeconomic status (MHAS 2012) There were 14,779 participants which were chosen by combining sampling and geographic convenience. The criteria for the selection of states included high quantity of urban population and rural population with a high prevalence of diabetes, and high migration rates to the US. The total sample was chosen based upon if they were above or the age of 55 and had partaken in a interview by proxy for health concerns.

Additionally, there were three parts to the survey: cognitive evaluation, adequate informant information, and performance measures. These were taken to create an equal and representative sample group. The cognitive evaluation consisted of questions that included aspects such as memory, depression, and history of skull trauma. The measurement was introduced with the Mini-Mental State Examination (MMSE) survey and continued with questions that included additional cognitive questions. If the participant scored under 10 on the MMSE the participant would receive less questions about their cognitive ability. Those who

scored greater than 10 received more questions regarding their cognitive health. The next part of the survey included questions from the Community Screening Instrument for Dementia (CSI-D). There was a long and short version. The long version was administered if participants answered correct to two or more of six questions that suggest cognitive deterioration is in existence. Otherwise, the participant was administered the short, 48 question test. The final measure included anthropometric and performance measures. For consistency, they were taken twice. Trained researchers measured scales such as blood pressure, height, weight, waist circumference, balance, walking speed, and grip strength. These were taken to understand overall health, mental and physical, and to understand how these affect cognitive abilities, and overall health effects. The data was collected in two phases. The first phase was collected between March through April while the second phase took place in October through November of 2015.

After obtaining the data from the MHAS database, the analyses were ran on Statistical Packaging for the Social Sciences (SPSS). On SPSS a t-test was ran to compare the mean differences between male and female access to healthcare. The t-test was chosen because it showed the mean differences in the two groups according to how much they used some typw of healthcare for their ADL's.

Measures

For the purpose of this paper, the major variables that were analyzed were access to healthcare, more specifically access to healthcare. Healthcare was measured by using the following variable: Activities of Daily Life (ADLs). ADLs include activities such as walking, feeding, dressing, using the toilet, bathing, and being able to move from one position to another.

Participants also claim whether they use a form, such as private or public, insurance. The groups were split into two depending on their gender and from there analyses were ran.

Results

The question that was trying to be answered while running these analyses was, "Do Mexican men have more access to healthcare than Mexican women. There was not a significant difference in the scores for men (M=-.724) and women's (M=-.750) access to healthcare conditions; t(1098)=.340, p= .470. The results show that there was no significant difference, however the results are trending toward men having slightly higher access.

Discussion

The aim of the study was to target the difference between access to healthcare in men and women. This was done through the use of a t-test and analyzing the means of access to help with ADL's from each group. Analyzing if there was a difference would indicate who has more access to healthcare. Given the fact that women do age quicker than men, their numbers should be a lot higher. By looking at the number of participants we can see that females did have higher participation rate than men showing that women do need more assistance with ADLs.

After running these analyses, there was no significant difference found. However, the results

were trending toward men having more access to ADL’s. These results show that men do have slightly easier access to healthcare than women. Though the difference was not significant, it is not surprising that it is trending towards significant.

From these findings we cannot conclude a significant difference but we can still say there is a difference between men and women. On a broad level, it is the culture of the United States that is affecting the healthcare system. The government limits job opportunities permits gender pay gaps, and only practices one approach to healthcare. As we can see, Mexican women are highly affected by this and so is their mental and physical health. The government does not place barriers on women, but they do not help them overcome problems that they are facing when facing healthcare. Specifically, when Mexican women immigrate to America, they are not providing them with the resources they need. The government should cater to individuals' needs and build a diverse healthcare system that matches the country’s diversity. On a more specific level, the gender differences in America need to be eliminated. More importantly, the gender differences between immigrants should be reduced as well. The government should provide a unique healthcare program for immigrants coming into the United States. Not only will it instill trust into new citizens, but help eliminate some of the issues discussed before such as language barriers.

However, the study did include some limitations. One limitation of this study is that secondary data analysis was used. Also, one important thing is that only one variable was used when running analyses. For future research, the findings would be more supported if there was more than one variable used. Even though ADL’s are indicators off access to healthcare, it would have also been interesting to see how much each group spends on healthcare, how often they access it, and how satisfied they are with the healthcare. Though the sample was representative of Mexican immigrants, it would be interesting to see if the number of years within the United States is a moderator of the two variables. With that being said, the number of years should not matter, each individual should have equal and fair access.

Some additional implications of the results indicate that the gender gap is not only specific to America, but also other countries. While some may think the gap only exists when speaking of power, money, or work positions, these results suggest that it is also relevant in healthcare as well. This is an issue that is just as important as the others that are going on in America. It should be addressed with sensitivity, understanding, and inclusivity.