Disparities and Access Barriers to Health Care Among Mexican American Elders

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12.1. Introduction

According to the year 2000 United States Census data, individuals from diverse racial and ethnic backgrounds are increasing, both in their absolute numbers and in their proportion to the general population. Among the elder population, the Latino population is projected to grow the fastest (Administration on Aging, 2000). In absolute numbers, it is expected that there will be over 13 million Latino elders by the year 2050. This would constitute or a change from 6% in 2003 of the population 65 and older, to 18% by 2050 (Federal Interagency Forum on Aging-Related Statistics, 2004). From this group, it is estimated that at least 4.5 million Latino elders will require Long-Term Care (LTC) (Markides, Rudkin, Angel, and Espino, 1997). Many of the same disparities and barriers that are present in younger populations continue into old age, when health care can be even more vital to a person’s quality of life. Older minorities tend to be in poorer health than the general population, have more functional impairments, more limited educations and lower incomes, and in turn bear more out-of-pocket costs, which can be more than 31% for those at the lowest income levels (Krisberg, 2005).

This study has two objectives. First, we examine access barriers to acute and long-term health care for Mexican American elderly as perceived by sociologists/gerontologists and public health policy experts (PHPs). Second, we assess the relative influence of chronic poverty (CP) as compared to other identified factors in patients’ accessing quality medical care services as perceived by the above professional groups.

In this chapter acute care is defined as medical treatment given to individuals whose illnesses or health problems are short term (usually under 30 days), and long-term care is characterized as a continuum of broad-ranged maintenance and health services delivered to the chronically ill, disabled, and others (U.S. Department of Health and Human Services, 1997).

Much research has been conducted in social gerontology and public health policy on Mexican Americans elders over the past two decades. Yet, systematic knowledge and agreement about health care disparities in access and barriers to acute and long-term care services varies within and between different professional,
academic, and health policymakers groups. For more than a decade, numerous panels, committees, and commissions have been appointed to address gaps in Latino health research. Nonetheless, the problem of inadequate data on Latinos persists. This is explained in great part by the lack of a concerted or continuous effort in the past and by the lack of influence of bodies commissioned to address these needs to monitor health policy implementation (Aguirre-Molina and Pond, 2003).

Racial and ethnic disparities in health outcomes have been observed among persons with similar health insurance, within the same system of care, and within the same managed care plan, (Bierman, Lurie, Collins, and Eisenberg, 2002). Although targeted interventions have narrowed and even closed some of these gaps, others persist. Research into the underlying factors contributing to health disparities and the design, implementation, and evaluation of interventions to eliminate them is needed. These efforts have been hindered by the general lack of standardized data on race and ethnicity in health care settings, because without these data disparities cannot be assessed (Bierman, Lurie, Collins and Eisenberg, 2002). On the other hand, in part, there is consensus on some core factors or barriers of LTC services use. Research has revealed an underutilization of long-term services by Mexican American elderly and holds that this is due in part to their lack of knowledge, lack of health insurance, use of informal networks, socio-institutional and socio-cultural barriers (Parra and Espino, 1992; Angel, Angel, Aranda, and Miles, 2004).

Poverty has many faces; it changes from place to place and across time, and has been described in many ways. To know what helps to reduce poverty—what works and what does not, what changes over time—poverty has to be defined, measured, and studied. Various definitions and concepts exist for poverty, one being whether households or individuals possess enough resources or abilities to meet their current needs. This definition is based on a comparison of individuals’ income, consumption, education, or other attributes with some defined threshold below which individuals are considered poor in that particular attribute. As poverty has many dimensions, it has to be looked at through a variety of indicators—levels of income and consumption, social indicators, indicators of vulnerability to risks, and of socio-political access (World Bank, 2006).

There is significant disagreement about poverty in the United States, particularly over how poverty ought to be defined. There are two versions of the federal poverty measure: the poverty thresholds (which are the primary version) and the poverty guidelines. The U.S. Census Bureau defines poverty as economic deprivation. A way of expressing this concept is that it pertains to people’s lack of economic resources (e.g., money or near-money income) needed for consumption of economic goods and services (e.g., food, housing, clothing, transportation). Thus, a poverty standard is based on a level of family resources (or, alternatively, of a family’s actual consumption) deemed necessary to obtain a minimally adequate standard of living, defined appropriately for the United States (U.S. Census Bureau, 2005a). The U.S. Census Bureau issues the poverty thresholds that are generally used for statistical purposes—for example, to estimate the number of persons in poverty nationwide each year and classify them by type of residence,