Use of the Health Care Delivery System by Urban Mexican-Americans in Ohio

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ALTHOUGH MEXICAN-AMERICANS represent the second largest minority group in the United States, little is known about the health status of this population. Yet, policies and planning for health services continue to be elaborated and acted upon with virtually no systematic information about mortality, morbidity, and health practices among this population (*1*). Further, the little that is known is based, to some extent understandably, on data gathered mainly in Texas and California. However, substantial numbers of Mexican-Americans now live in the northern and midwestern regions of the country, and little is known regarding their health needs and practices (*2*). These northern residents are largely urban, as are 80 percent of all U.S. Mexican-Americans, but most data available, beginning with the early anthropological health analyses (*3*), focus predominantly on rural populations.

Thus, at this point, policymakers are in the precarious position of planning health services without any knowledge of the appropriate needs or the organizational arrangements for a Mexican-American population. If services are organized, will they be used by the target population? Such a question has no immediate answer due to the lack of available data for planning purposes.

To begin to fill some of these research gaps, we provide data on some health care utilization patterns of an urban Mexican-American population in Ohio. We describe some characteristics of the population and examine the enabling factors of income and health insurance (*4*) as they relate to responses to illness and source of treatment. Health planners and policymakers need to understand these variables, representing "characteristics of the population at risk" and "utilization of health services" within the access model (*5*), because they are mutable; that is, they can be affected by health policy decisions.

Background

The health utilization literature dealing with Mexican-Americans has been focused primarily on cultural and psychological variables. Weaver's 1973 review (*2*) of the health behavior literature on Mexican-Americans cited three generations of research. The first generation focused on health care as a function of subcultural beliefs and practices, largely from a nonsystematic data base (*3*). The second generation adopted this culture orientation and provided anthropological supporting evidence, again based on limited observations (*6*). The third generation began to use surveys and sociological techniques and questioned folk culture ideology. Inadequacies in health services were now highlighted from the perspective of new responsibilities; consumers' needs were to be considered in the provision of health care.

However, the third generation research efforts focused predominantly on attitudinal variables. Factors such as alienation (*7,8*), extent of assimilation (*9*), multidimensional "social characteristics" (*10*), familism (*8*), cosmopolitanism (*11*), and language and communication barriers (*12*) as they affect health behavior account for the bulk of the recent literature. Only three relatively recent reports have focused on morbidity and

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mortality patterns and associated structural and organizational variables (*13–15*), all based on data obtained from the West and Southwest. The additudinal studies cited also used southwestern regional data, leaving present knowledge about Mexican-American populations in other areas such as Illinois and Ohio sparse indeed.

We sought to determine whether this ethnic population responds positively to the health system when given the opportunity and to attempt some assessment of those arguments that stress the unique social and cultural barriers of this population to needed health services. Do factors such as assimilation levels or ethnicity really decrease Mexican-Americans' faith in "scientific medicine" (*16*)? Or, will they use "scientific" health services when they are made available? These questions are important for policy and planning decisions as they affect the levels and organization of health services.

Study Methods

In 1973, a neighborhood health center was planned to serve a large, urban Mexican-American population living in a well-defined catchment area of a large city in Ohio. To determine what level of services might actually be needed, a needs assessment and a health survey plan were carried out.

Sample. Data from the 1970 census were examined for households of Spanish origin, and those tracts most densely populated with Mexican-Americans became the target survey areas. The names of Mexican-American families were initially gathered from as many sources as possible, including church records, schools, telephone directories, and voluntary community organizations. These sources were generally expanded by referrals to other sources, in the fashion of an exploding sample. The names of more than 1,500 families were obtained as potential respondents.

Instrument. Questionnaires designed to obtain general family information from the household head and personal health histories of all family members were prepared in both Spanish and English. The content of the questionnaires was screened for approval by leaders of the Mexican-American community. Questions they judged not directly pertinent to a health survey, such as education levels, were deleted. After a short trial of mailing questionnaires, which yielded a response rate of only 18 percent, we decided to conduct door-to-door interviews. In the absence of a definitive population to sample at random, a survey of health needs and illness levels must be as inclusive as possible to provide reasonably unbiased results.

Procedures. To keep the refusal rate low and to produce maximal cooperation, we selected nine bilingual interviewers from the community being surveyed (*17*). All interviews were conducted in the families' homes. If daytime hours yielded no response, return visits were made during evening hours. The questionnaires were completed jointly by respondents and interviewers, in either Spanish or English. This method yielded a total of 929 surveyed families and a total of 4,345 individual personal health histories. The interviewing took several months. When it was completed, the data were processed and stored on computer tape for subsequent analysis.

Results

Tables 1 and 2 show selected characteristics of the individuals and household heads in this northern, urban Mexican-American population. Clearly, the group was predominantly young—72 percent were under 30 years old. The average household contained about five persons. Of the sample of 4,345 persons, 79 percent had experienced some illness and 45 percent had been hospitalized, which indicated substantial encounters with the health care system.

Among the household heads, one-third were born outside the United States, and almost 60 percent of these cited Mexico as their country of origin (origin was defined as birthplace of grandparents). About 73 percent of the families spoke Spanish alone or were bilingual.

The population was predominantly poor—62 percent had incomes of less than $7,000. Although more than 70 percent held full-time jobs, unemployment was unusually high (19 percent) among the household heads. Generally, it appears that cultural marginality—with ties to two unique world views—as well as poverty might characterize this population. Based on previous research, we might expect a population with such characteristics to be removed from the established health care delivery system.

The extent of experience with the health care system among this population is evident from the relation between income and type of health insurance, as shown in table 3. The data clearly demonstrate the expected positive relation between the variables. Although health insurance is strongly related to employment status, few jobs yielding total annual household incomes of less than $4,000 or even less than $7,000 provide paid health insurance as a fringe benefit. Since income is directly related to employment status, persons with low incomes are not likely to have paid health insurance coverage. In fact, of those in the lowest income group (under

$4,000), 40 percent had no health insurance of any kind. However, in the same income group, about 33 percent were covered by some form of private insurance.

Thus, substantial numbers of persons in the sample willingly paid for health insurance from limited personal resources. It follows, then, that they were aware of the present health services system and would turn to it if they were ill. That an additional 28 percent were covered by Medicaid and other nonprivate insurance also suggests awareness of and willingness to use existing health services. The higher income groups demonstrated a markedly high concern with meeting health care needs. More than 80 percent of those earning $4,000–$6,999 (many without job-related benefits) and more than 80 percent of those in the $7,000–$9,999 income group had some type of private health insurance. Among those with incomes of $10,000 and over, 95 percent had private health insurance coverage.

The sources of treatment for their most recent illnesses are shown by income groups in table 4. As might be expected, the highest income group was least likely to use clinic or emergency room services when ill. Both the highest and the lowest income groups were most likely to visit a private physician in his office. The high rate of office visits by those with the lowest incomes may be due to their use of Medicaid as a pay-

Table 1. Selected characteristics of 4,345 persons in household survey

Characteristics	Number	Percent
Sex:		
Male	2,115	48.7
Female	2,230	51.3
Age group (years):		
0–9	1,317	30.3
10–19	1,224	28.2
20–29	613	14.1
30–39	427	9.8
40–49	386	8.9
50–59	203	4.7
60 and over	175	4.0
Family position:		
Household head	929	21.8
Spouse	771	17.6
Son	1,290	29.6
Daughter	1,300	29.8
Other	55	1.2
Ever sick:		
Yes	3,452	79.4
No	893	20.6
Ever hospitalized:		
Yes	1,981	45.6
No	2,364	54.4

Table 2. Selected characteristics of 929 heads of household

Characteristics	Number	Percent
Country of birth:		
United States	619	66.6
Mexico	293	31.5
Others	17	1.9
Country of origin:		
United States	363	39.1
Mexico	544	58.6
Others	22	2.3
Language spoken in home:		
English	253	27.2
Spanish	280	30.1
Both	396	42.6
Income:		
$ 0 –$3,999	292	31.4
$ 4,000–$6,999	290	31.2
$ 7,000–$9,999	227	24.4
$10,000 and over	120	12.9
Employment status:		
Full time	662	71.3
Part time	28	3.0
None	179	19.3
Other	60	6.5

Table 3. Family income and type of health insurance for 4,286 persons

Family income	None		Blue Cross		Other private		Medicaid		Other nonprivate		Total
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	
$ 0 –$3,999	431	39.7	223	20.5	131	12.0	279	25.6	24	2.2	1,088
$ 4,000–$6,999	157	11.4	978	70.9	148	10.7	45	3.3	51	3.7	1,379
$ 7,000–$9,999	136	11.6	756	61.9	249	20.4	23	1.9	57	4.7	1,221
$10,000 or more	13	2.2	355	59.4	212	35.5	0	0.0	18	3.0	598
Total	737	17.2	2,312	53.9	740	17.3	347	8.1	150	3.5	4,286

ment mechanism, which again suggests a desire to use existing health services when possible. It is interesting that the overall use of private physicians versus clinics or emergency rooms was almost identical for the sample as a whole.

The data in table 5 demonstrate further how payment mechanisms as well as income might affect treatment source. For persons who responded negatively when asked if they had been treated by a doctor for their most recent illness, the data do not differ substantially from the data for the sample as a whole (table 3). The negative responses to "treated by a doctor" appear to be a reaction to absence of perceived illness—not uncommon among such a young sample—

Table 4. Sources of treatment for recent illnesses of 4,345 persons

Family income	Physician's office		Home		Clinic or emergency room		None	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
$ 0 –$3,999	277	25.5	9	0.8	212	19.5	599	55.1
$ 4,000–$6,999	201	14.3	23	1.6	361	25.8	817	59.3
$ 7,000–$9,999	253	20.4	20	1.6	231	18.6	737	59.4
$10,000 or more	159	26.3	7	1.2	82	13.6	357	59.0
Total	890	20.5	59	1.4	886	20.6	2,510	57.8

Table 5. Distribution of 4,286 persons not treated by a physician, treated in a physician's office, or treated in a clinic or emergency room for recent illnesses, by family income and type of health insurance

Family income	None		Blue Cross		Other private		Medicaid		Other nonprivate		Total
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	
Not treated by physician											
$ 0 –$3,999	234	39.1	107	17.9	95	15.9	146	24.4	17	2.8	599
$ 4,000–$6,999	109	13.3	567	69.4	92	11.3	22	2.7	27	3.3	817
$ 7,000–$9,999	88	11.9	455	61.7	140	19.0	17	2.3	37	5.0	737
$10,000 or more	8	2.2	200	56.0	144	40.3	0	0.0	5	1.4	357
Total	439	17.5	1,329	53.0	471	18.8	185	7.4	86	3.4	2,510
Treated in physician's office											
$ 0 –$3,999	93	33.6	69	24.9	26	9.4	84	30.3	5	1.8	277
$ 4,000–$6,999	13	6.5	138	68.7	27	13.4	13	6.5	10	5.0	201
$ 7,000–$9,999	19	7.2	155	61.3	63	24.9	2	0.8	14	5.5	253
$10,000 or more	4	2.5	104	65.4	39	24.5	0	0.0	12	7.6	159
Total	129	14.5	466	52.4	155	17.4	99	11.1	41	4.6	890
Treated in clinic or emergency room											
$ 0 –$3,999	105	49.5	47	22.2	10	4.7	48	22.6	2	0.9	212
$ 4,000–$6,999	35	9.7	273	75.6	29	8.0	10	2.8	14	3.9	361
$ 7,000–$9,999	29	12.6	146	63.2	46	19.9	4	1.7	6	2.6	231
$10,000 or more	1	1.2	51	62.2	29	35.4	0	0.0	1	1.2	82
Total	170	19.2	517	58.4	114	12.9	62	7.0	23	2.6	886

and personal choice of home treatment, rather than the influence of income or insurance mechanism. Further examination of the illness patterns among such a group is an important area of future research.

Persons treated in a physician's office were slightly more likely to have some form of health insurance (table 5). In the lowest income group, about one-third had no insurance; an additional third, private insurance; and nearly one-third were covered by Medicaid. The desire to use scientific medicine appears strong in this sample, since one-third of the lowest income group having no insurance still chose to see a physician in his office when they became ill. Other income groups showed insurance patterns similar to those presented in table 3. Persons "treated in a clinic or emergency room" (table 5) manifested enabling characteristics similar to those who used other treatment sources or none at all. Among those earning less than $4,000 about half (49 percent) had no insurance of any kind. In other words, those who use clinic services and are poor are also most likely to not have health insurance coverage.

Discussion

The data presented illustrate the influence of income on the source of treatment. As expected, income also appears to be an important predictor of private health insurance coverage, but only for very low incomes versus higher incomes. Moreover, private health insurance was more widespread in this sample than would be expected on the basis of employment status. In fact, those with incomes exceeding as little as $4,000 were likely to have private insurance coverage. This finding indicates that our sample placed a high value on medical protection as offered by the health care system.

The readiness to seek care in the physician's office among all income groups also suggests the voluntary involvement of what one might have expected to be a marginal population in the present health services system. It indicates a faith in scientific medicine which other researchers had suggested did not exist. Although the population studied had such qualitative characteristics as exclusivity (*16*), lack of assimilation (*9*), and language-communication barriers (*12*), their willingness to seek care within the system, even among those for whom such care strains financial resources, suggests that access is the more important determinant of utilization for these Mexican-Americans.

It appears that "health policy," which can affect financing, education, manpower, and, most importantly, organization of health services (*5*), if effectively balanced could alleviate some health care problems of northern U.S. Mexican-Americans. The data presented clearly suggest a positive response of this northern, urban population to modern, "scientific" health care services, despite the relative poverty and apparent "marginality" of the people. If health needs are carefully defined, services are planned in conjunction with community members, and some bilingual personnel are provided, active participation in a health care delivery system by such populations can be expected.

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