

Mexican immigration

Countries



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Mexican immigration has been considered as a distinct event that occupies a place in the history of United States immigration. There are currently millions of Mexican Americans in the U. S., occupying almost all regions of the country. Their immigration started in the 20th century and the influx of Mexicans is still continuing to date. The culture of Mexico and its US immigrants is complex, representing a combination of Spanish, Mexican and other indigenous tribal traditions and beliefs.

The significant migration of Mexicans to the US has influenced the judiciary and public systems of the US. In addition, legislative rulings regarding immigration have been constantly changing since the 20th century, mostly due to the Mexican migration. Interestingly, the US society has also experience variations in reception of these migrant individuals, ranging from a warm welcome to a cold feeling for unsolicited migrants. In return, the Mexican immigrants have learned to adapt to an ever-changing treatment in the US and have become skilled at defending themselves from US citizens that show prejudice towards them.

Today, a huge portion of the US population is composed of Mexican immigrants. Their numbers in the US have made them prominent social and cultural group, influencing the employment of the Spanish language in most of the public services and commercial products. The Mexican food has been around the US for hundreds of years now, with its meals being a staple even to non-Mexican US citizens.

The growth of the Latino population in the United States has resulted in the significant observation of social and economic risk factors that are associated

with health. Mexican-Americans or the Latino population comprise the largest group of immigrants in the United States. Studies have revealed that the concept of having Mexican origins was an independent risk factor that influences conditions of being uninsured. Even though the word “Latino” is an acceptable descriptor for this specific population, other groups categorized this ethnic group as “Hipic.” Several studies have attempted to describe and evaluate the socio-demographic features of Mexican-Americans, including the health conditions and healthcare needs of this specific population (NIH, 2006).

The Mexican-American population is considered an immigrant population, hence it should also be noted that it takes time for this population to totally settle down in the United States (Schmidley, 2001). Studies show that first-generation Mexican American families experienced a more difficult living condition than subsequent generation. These include family income level, educational attainment and language. It has been generally observed that approximately 65% of the first-generation Mexican-Americans lived in poverty, and 75% of the heads of Mexican-American household possessed less than 9th grade education. It is also interesting to know that less than 10% of the Mexican-American households had a good command of English.

First-generation Mexican American children had the highest rate of being uninsured (64.2%), which was significantly higher than the percentage reported for Hipics as a whole. Significant differences persisted for the second- and third generation groups. In fact, each generational group of Mexican American children was more likely to be uninsured than either non-Hipic white children or black children.

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It is also interesting to note that, among first-generation Mexican American children, there were almost equal proportions of children with private and public health insurance. This is not surprising, because 70% of the heads of household were employed. A significantly greater proportion of first-generation children could be insured if their parents worked for employers who provided health insurance. Even when insurance is offered, however, many employed Hispanics in poor and low-income households decline coverage because of lack of affordability.

Previous reports that immigrant children as a whole are less likely to have health insurance, less likely to have a usual source of care, and less likely to have had a doctor's visit in the past year were limited in that they did not differentiate Hispanic subgroups or generations. First-generation Mexican American children had much worse health care access than previously described for Hispanic children as a whole. Previous studies show that majority of Hispanic children had a usual source of care. With regard to immigrant children, 51% of all foreign-born children (including Latino, white, black, and Asian children) in working-poor families were uninsured and that 65% had a usual source of care, suggesting that first-generation Mexican American children may also fare worse than immigrant children considered as a whole. Even when first-generation Mexican American children were insured, they had the lowest likelihood of having a regular source of care or a specific provider.

First-generation Mexican American children also demonstrated the lowest levels of utilization of health care services, as assessed by visits to a physician, use of prescription medications, and screening for hearing and

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vision problems (Holl et al., 1995; Weinick and Krauss, 2000). Poor health care access is a known predictor of poor health care utilization; however, the data also suggest that the first-generation group might have had decreased needs. For example, fewer reported earaches/infections in the first-generation group and lower levels of treatment for ear infections were consistent with fewer visits to a physician for earache/infection.

First-generation Mexican American children also had lower rates of reported cold or flu, pneumonia, and ear infections, which were consistent with lower rates of prescription medication use. Better health outcomes in recent immigrant populations form the basis of what has been described as the “epidemiologic paradox” (Trevino et al., 1991). Despite the presence of demographic and socioeconomic risk factors, foreign-born Mexican American women have low birth weight infant birth rates and infant mortality rates similar to those of white women.

It has not been confirmed that any advantage at birth persists into early childhood, and study results are conflicting. Mexican American mothers report low rates of asthma, coordination problems, psychologic and behavioral problems, speech problems, and mental retardation among their children, suggesting that immigrant children may fare better with regard to specific illnesses.

A substantially higher number of first-generation Mexican American households reported Spanish as the primary language spoken and also had lower levels of health care access and utilization, compared with the other groups (Kurzon, 2000). Hispanic parents identify language problems, long waits

at the physician's office, lack of health insurance, difficulty paying medical bills, and difficulty arranging transportation as the greatest barriers to care (Halfon et al., 1997).

However, several may not bring their children in for care if the medical staff does not understand Hipic culture. This is an important realization that points to systemic factors, as opposed to individual patient factors, as causes of racial/ethnic disparities in health care. The cultural shortcomings of clinical staff, including lack of Spanish language proficiency, lack of knowledge of Hipic culture, and lack of Hipic staff members, cannot be underestimated. Additional research is required to identify the specific barriers to health care access and utilization for specific population subgroups, the benefits of a culturally competent and language-friendly clinical environment, and the costs of creating and maintaining such an environment.

Indeed, culture, cultural perspective, and/or cultural differences may account for a portion of the difference attributed to generational status (Jackson and Heroux, 1999). One of the most studied measures of acculturation, namely, language, reflected the first-generation Mexican American households, with most being primarily Spanish-speaking. Although the definitions of acculturation varied, past studies that used language preference as a measure of acculturation showed increased use of preventive services and decreased perceived barriers to care for Hipics who spoke English.

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groups. The language and culture of the medical office may have disproportionate effects on utilization of health care for first-generation immigrants (http://findarticles.com/p/articles/mi_hb4389/is_200410/ai_n15294610).

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First-generation Mexican American children also demonstrated the lowest levels of utilization of health care services, as assessed by visits to a physician, use of prescription medications, and screening for hearing and vision problems. Poor health care access is a known predictor of poor health care utilization. The first-generation group might have had decreased needs. For example, fewer reported earaches/infections in the first-generation group and lower levels of treatment for ear infections were consistent with fewer visits to a physician for earache/infection.

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The generational status alone may account for lower developmental scores among Mexican American children. Lower rates of specific illnesses among first-generation Mexican American children seem to support the epidemiologic paradox, suggesting that first-generation Mexican American children had decreased health care needs with respect to the conditions reported. This might have translated into decreased utilization of health services for this group. The theory that Mexican American children become less healthy as they become more acculturated has now been assessed and reviewed. Subsequent generations reported higher prevalence of the illnesses tested, adding to evidence in the literature that Hispanic immigrant

children have health outcomes and indicators that worsen with greater acculturation and each successive generation (NIH, 2007).

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