Double jeopardy: In the United States, Latino women face increased health disparities compared to Latino men and white women, and may drive the observed disparities for this minority

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Latinos comprise the largest minority group in the United States, representing nearly 15 percent of the nation's 300 million people, and they are the nation's fastest growing minority group (U.S. Census Bureau, 2010; Latinos, 2007). That growth is predicted to continue, and by 2050, one-fourth to one-third of U.S. residents will be Latino (Bergad & Klein, 2010).

For all U.S. minorities, health disparities are a fact of life (Hayes-Bautista, 2002), and disparities are particularly acute for Latinos. Numerous studies have documented differences in health outcomes between the Latino minority group and the dominant white population, including higher death rates from HIV/AIDS, diabetes, homicide, chronic liver disease, and cirrhosis; higher rates of tuberculosis, cervical cancer, chronic kidney disease, obesity, stomach cancer, teen pregnancy, and sexually transmitted diseases; lower childhood immunization rates; and, greater delays in reporting breast cancer symptoms (American Cancer, 2011; Hayes-Bautista, 2002; Hispanic, 2009; Maguire et al., 2010; Organista, 2007).

Researchers also have found differences in health-seeking behaviors: Latinos are less likely to seek colorectal, prostate or breast cancer screenings (American Cancer, 2011), and less likely to use non-emergency ambulatory care than whites (Zuvekas & Tallaferro, 2003); Latino women are less likely to receive blood pressure checks and Pap tests than African-American or white women (Sambamoorthi & McAlpine, 2003). Although the Internet is an important source of health information for consumers Latinos are less likely than whites to have home access to the Internet (55 percent vs. 75 percent) (Fox, 2011).

When they do seek medical services, Latinos receive lower quality of health care than whites (IOM, 2003). Latinos were more likely to report delays or difficulties in obtaining care than other racial or ethnic groups (Zuvekas & Tallaferro, 2003) and less likely to report that health providers showed respect, listened carefully, or spent enough time with them (Ok, Marks, & Allegrante, 2008). One study reported that two-thirds the 234 Latino adults surveyed said they did not seek colon cancer screening because no one mentioned it to them (Cameron, Francis, Wolf, Baker, & Makoul, 2007). Not surprisingly, Hispanics were less satisfied with the health care their family received and reported lower quality of health, a resurgent theme that has seen little change over the last decade (D'Anna, Ponce, & Siegel, 2010; Waidmann & Rajan, 2000).

A major reason for health disparities among Latinos is lack of health insurance, which limits access to preventive, diagnostic, and therapeutic services. More than one-third of Latinos in the United States have no health insurance, twice the rate of uninsured non-Latino residents (Brown & Yu, 2002; Lille-Blanton & Hoffman, 2005; Zuvekas & Tallaferro, 2003). Uninsured Latinos were less likely to have a regular source of health care and less like to visit a physician, compared to Hispanics with health insurance (Cheong, 2007). Among uninsured Latinos, half reported they had not seen a doctor when last sick, had gone without a prescription, or had gone without recommended tests or treatments (Carillo, Treviño, Betancourt, & Coutasse, 2001). Latinos were more likely than whites to be without a health provider (Lille-Blanton & Hoffman, 2005). Not surprisingly, Latinos are more likely than whites to report their health care quality as poor. "Lack of health insurance creates significant barriers to obtaining needed health services, exacerbating disparities in access and health status between Latinos and non-Latino whites" (Brown & Yu, 2002, p. 236).

A key reason for these disparities is discrimination against the minority population by the majority group (Organista, 2007), which positions Latinos at a disadvantage economically, educationally, and culturally, and, ultimately, negatively impact health outcomes. In the United States, where health insurance is closely tied to employment, Latinos face barriers to health care because they are less likely than whites to have employer-sponsored coverage (Lille-Blanton & Hoffman, 2005). Latinos are less likely to graduate from high school than whites, less likely to occupy management and professional positions, more likely to have lower median incomes than whites, and more likely to be employed in hazardous jobs (Bergad & Klein, 2010; Friedman-Jiménez & Ortiz, 1994). "The lack of health insurance is one of the most serious barriers that Latinos currently confront in obtaining health services" (Giachello, 1994, p. 86). Undocumented status for Latino immigrants also constitutes a significant barrier in obtaining both preventive and curative medical services (Molina, 2011).

Yet, in spite of the disadvantages, there is an "epidemiological paradox" (Hayes-Bautista, 2002, p. 218). Latinos have life expectancy rates that surpass whites (Amaro & de la Torre, 2002); the age-adjusted death rate for Latinos is 376/100,000, nearly 20 percent lower than for non-Hispanic whites. Additionally, Hispanics use fewer mental health services than whites even though needs are equivalent (Hayes-Bautists, 2002; Organista, 2007), and Hispanics have lower rates of heart disease, prostate cancer, breast cancer, and lower rates of death from stroke and lung cancer than non-Hispanic whites (Cultural, Nd; Hispanic, 2009). Although Hispanics do not have equal access to the Internet, they use the Internet for health-seeking information in the same proportion as whites; approximately 50 percent report they have used the Internet to obtain health information (Raine & Spooner, 2001; Geana, Kimminau & Greiner, 2011).

There is a growing body of research on Latino health, but research is problematic: Latinos are not a uniform group; they are a "highly heterogeneous population that defies easy generalizations" (Suárez-Orozco & Páez, 2002, p. 3). Therefore, essentialist notions are not applicable in health research and policy. Latinos in the United States come from more than a dozen countries, including Cuba, Mexico, Puerto Rico, the Dominican Republic, and other Central and South American countries, and there are variances in socioeconomic status, educational levels, and employment situations, and variances in levels of acculturation (learning or adapting to new culture) and assimilation (adopting the new culture and leaving old ways behind).

Scholars suggest that, in spite of differences among Latinos, members of the group share common cultural bonds, which unite them but also mark them as different from the dominant white group (Flores, 1997) and ultimately create barriers to health care. Scholars note that Latinos share a holistic view of health that posits a link between physical health and mental well-being; a view of family, including extended family and loved ones who are not blood relatives, as sources of emotional support and advice and partners in health-care decision-making; the perspective that religion, particularly Catholicism, shapes individual, family, and community life; and a preference for collectivist values or group orientation rather than individualism (Cultural, nd; Giachello, 1996; Rodriguez-Triás & Ramírez de Arellano, 1994; Organista, 2007). The concept of *personalismo*, trust and support established by the development of a friendly relationship, runs counter to the customary concept of business and professional relationships in doctors' offices, where providers may confuse informality with personal interest (Organista, 2007). Hispanics may distrust medical providers, who live outside their communities, instead seeking self-care or home remedies when they cannot afford services (Cultural, Nd.).

Language also has been cited as one barrier to health care services (Leybas-Amedia, Nuño, & Garcia, 2005; Valdez, Giachello, Rodriguez-Trias, Gomez, & de la Rocha, 1993). Health care providers may not speak Spanish, and Latino patients may not have enough knowledge of English to understand providers' questions or instructions. "Understanding a patient's language is the beginning of understanding her or his health and illness beliefs and behavior and facilitates treating the patient as a whole person, and not just a configuration of disease symptoms" (Giachello, 1996, p. 159). Eighty-three percent of immigrant Latino youth reported that Spanish was spoken primarily or exclusively in their homes. One in five Spanish-speaking Latinos report they did not seek medical care because of language differences (IOM, 2003), and Latinos who are not comfortable speaking English have different levels of trust for providers than Latinos who are more comfortable with English (Clayman, Manganello, Viswanath, Hesse, & Arora, 2010).

Compounding disparities within this ethnic group is the invisibility of gender. Critics argue that the U.S. health system has long excluded minorities and women. Historically, medical research has been conducted primarily on white men and that limited knowledge broadly applied to women and minorities (Bayne-Smith, 1996; Hayes-Bautista, 2002). Traditionally, white men have worked as physicians, holding the knowledge and power in a health-care relationship (Bayne-Smith, 1996), and patriarchal attitudes have meant that women's symptoms were less thoroughly investigated than men's (Goudsmit, 1994). Women are less likely than men to report excellent or good health, but they account for nearly two-thirds of medical visits and the majority of prescriptions (Watkins & Whaley, 2000). Women are more likely than men to report they were unable to get medical, dental care or prescription medicines (Healthcare, 2010).

For Latinos, gender and ethnicity combine to create “multiple jeopardy” for Latinas trying to secure educational, economic, and health resources (Falicov, 1998). Traditionally, women assume most of the burden for unpaid domestic labor in taking care of the home and family, and when they do work outside the home, their salaries are typically lower than men’s: The dual discrimination of race and gender place Latino women on the lowest rung of the economic ladder. In 1999, the median income for Latino women in the United States was $12,910, compared with $18,570 for white women; concomitantly, Latino men would earn $18,430, about $6,000 more than women(Suárez-Orozco & Páez, 2002). Additionally, the number of households headed by women increased from 1980 through 2005, and female heads of households typically earn less than their male counterparts. Forty-three percent of Latino households are headed by women, compared to 27 percent of white households (Bergad & Kline, 2010), and Latino families headed by women were twice as likely to live in poverty as households headed by white women (Acuña, 2003).

This lower socioeconomic status translates into poor health outcomes for women. Amaro and de la Torre (2002) argue that gender cannot be separated from race, ethnicity, or class in health research, noting that “it is critical to build an understanding of health that considers the extent to which Latinas most at risk for health problems are affected by oppression based on gender, race/ethnicity, and class” (p. 527).

Critics also argue that health research must take into account cultural values and gender norms that place women at an economic disadvantage. In Latino culture, women and men may be encouraged to value and follow traditional gender roles, with men working outside the home to earn a living and women performing the majority of household tasks, including child care (Abalos, 1993). Latino culture supports machismo, “a kind of exaggerated masculine bravado,”

and mariansimo, the idea that "women accept undue burdens and suffer in silence" (del Castillo, 1998, p. 497). While some white feminists interrogated motherhood as an oppressive institution in women's lives (Rich, 1974), Latina and black feminist scholars have suggested that women's maternal roles are valued and are a means to gain power within the family and community (Iglesias, 1998), and the woman who does not conform to traditional feminine roles is the *mala mujer* (del Castillo, 1998, p. 500). "For Latinos, cultural norms and myths of national origin intersect with these patriarchal notions of a women's role and identity" (Rivera, 1998, p. 502).

In traditional gender role constructs women encounter a patriarchal irony: They are supposed to be economically and emotionally dependent upon men, yet others are dependent upon them to fulfill the roles of caretaker and nurturer (Ettore, 1994). The second wave of the feminist movement in the United States questioned these roles as oppressive, but Latina scholars have suggested that the movement often focused on the needs of white middle-class women and ignored racism and classism (Pesquera & Segura, 1998), two factors that can affect women's access to educational and economic resources. "The health status of women of color in the United States has been determined to a large extent by the powerful abilities of race and gender to define as well as institutionalize who has access to resources, how much and what kind of resources are available to certain groups, and the manner in which those resources are provided" (Bayne-Smith, 1996, p. 1).

Although a significant number of studies have examined ethnic-driven health disparities, comparing Latino and non-Latino populations, research on factors affecting Latino women's health is limited. "The inadequacy of data collection measures have (sic) contributed to the development of bad policy and poor health status among Latino women" (Giachello, 1996, p.

131). The current study aims to help close this knowledge gap by exploring how gender influences observed health and health-information use disparities among Latinos.

Methods

The purpose of the study was to examine perceptions of health and health disparities between Latinos and non-Latinos and among Latinos.

This study uses data from the September 2010 Health Tracking Survey conducted by the Pew Research Center's Internet and American Life Project and is part of a larger effort to examine factors that affect health behaviors and outcomes and help define health disparities in the U.S. population. The data collection was conducted through a telephone interview administered between August 9 and September 13, 2010, by Princeton Survey Research Associates International. The national sample consisted of 3,001 adults, age 18 and older, including 1,000 cell phone interviews. Of these, 233 respondents identified themselves as Hispanic/Latino. Because the aim of this study was to explore Latino health disparities in contrast with the white majority, a random sample of 235 white participants was selected from those respondents who identified themselves as whites only..

From the 150 variables utilized by the Pew study, we retained for analysis only those variables addressing ethnicity, gender, income, internet access and utilization, and those exploring health care dimensions (such as perceived quality of life and health insurance)

Descriptive statistics as well as nonparametric statistical tests were used to quantify observed differences between groups; SPSS statistical package was used to perform the statistical analysis.

Findings

Our research found that gender and ethnicity combine to affect income, health status, and quality of life.

The sample consisted of 60.7 percent women and 39.3 percent men. There were no statistic significant differences in gender distribution between the Latino and white samples.

Our initial comparisons of income found significant differences between Latino and white participants with 30 percent of Latinos earning less than $20,000 per year, compared to only 10 percent of the random sample of non-Latinos [$t(8, 468)=38.32$, $p<.001$]. Although Hispanic men earned significantly more than Hispanic women, we found no significant differences between their earnings and those of white men, thus observed results were driven mainly by women income [$t(1,282)=5.081$, $p<.001$].

Ethnicity and gender were important factors driving participants' perceptions about quality of life. Latinos perceived they had poorer quality of life than whites, with 14 percent of Latinos saying their quality of life was fair or poor, versus nine percent of whites reporting fair or poor quality of life [$\chi^2(4,468)=14.86$, $p<.05$). There were no differences in perceptions between men in the two groups, with 10 percent of Latino men reporting fair to poor quality of life, and 11 percent of white men reporting the same, but Latino women perceived they had poorer quality of life than non-Latino women, 17 and seven percent respectively. This was a statistically significant difference [$\chi^2(3,282)=19.65$, $p<.001$)]. Regarding access to health care, Latino women reported increased levels of Medicaid coverage or no coverage at all, compared to Latino men and non-Latino women [χ^2 $(3,284)=20.16$, $p<.001$)].

With Internet use, there were statistically significant differences between Latinos and whites, with only 61 percent of Latinos using the Internet, compared with 72 percent of whites [(χ^2 (2,468=6.40, p<.05)]. There were no significant differences within the ethnic group regarding overall Internet use, although Latino women state that they use the Internet slightly more than Latino men, 64 percent vs. 58 percent, respectively. Nevertheless, when asked about recent Internet use (in the past day), Latino men overwhelmingly surpassed Latino women, 82 percent vs. 61 percent, respectively [(χ^2(1,149)=7.21, p<.01)]. Similar to the observed income disparities, this gender difference in recent Internet use is driven by women: There were no statistically significant differences between Latino and non-Latino men (81 and 80 percent), and Internet use by white women was comparable to that of both male groups. However, differences in Internet use among the two groups of women was significant, with only 61 percent of Latino women saying they had recently used the Internet, compared with 81 percent of white women [(χ^2(1,196)=10.31, p<.001). With women playing a major role in families' medical decisions, the observed disparities in Internet use translates into disparities with regard to access to health information: Looking online for information about a specific disease or medical problem [χ^2(2,196)=6.69, p <.05)]; searching online information about a certain medical treatment or procedure [χ^2(1,196)=7.91, p.<.05)]; obtaining information about doctors or other health professionals [(χ^2(1,196)=4.68, p<.05)]

Conclusions

This study reinforces previous research that suggests minority women fare worse than white women in terms of access to health care, and research highlights the intrinsic impact that gender-driven disparities may have on reported data for Latinos. Scholars have written about

overlapping oppressions and how the intersections of race and gender can compromise an individual's quality of care. This study shows that being Latino and female translates into poorer health than being Latino and male.

Because Latino women make less money than white and Hispanic men and less money than non-Latino women, they also may have less ability to pay for health care—either out-of-pocket or through insurance. Furthermore, actual access and use of the Internet is significantly lower among Latino women, thus translating into less access to a readily available source of health information, a situation that may reflect negatively over their family, especially considering the increased number of Latinas who are single parents.

The relationships among health, communication, and culture have been poorly examined (Freimuth & Quinn, 2004), and scholars have suggested the need for providers to become culturally competent, which "maximizes the probability of being effective in problem-solving and minimizes the probability of insensitive and incompetent approaches that reveal and reify our biased socialization" (Organista, 2007, p. 120).

We agree but also suggest the need for providers to consider gender competence in developing health research, education, and interventions programs. Our findings suggest gender should be given the same level of attention as ethnicity when analyzing health disparities data, and that researchers should look further into possible drivers of disparities within ethnicities. There is an urgent need to understand how gender norms, which position women as passive and home-focused and men as aggressive and work-focused, affect women's access to health care, health information, and health outcomes. Such an approach would provide a better causal understanding and drive more pertinent and focused interventions to help decrease disparities.

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