RETIRING IN A FOREIGN LAND: HEALTH CARE

ISSUES OF US RETIREES IN MEXICO

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This research examined the health care related issues of the American seniors retiring in Mexico. Data for this study were collected through in-person questionnaire surveys and case studies. Findings of this study indicate that US seniors retiring in Mexico are predominantly non-Hispanic whites, married, and more likely to be college graduates. This study challenges the general perception that US seniors move to foreign countries is “amenity-led.” The case studies clearly show that many US seniors move there because they are afraid that with reduced income and increased health care needs they would not be able to maintain the same lifestyle after retirement in the US. Climate and the slower pace of life are two other big attractions for seniors’ to move to Mexico. A major finding of this study is age, gender, education, use of Medicare for medical care coverage, and chronic medical condition are significant predictors of US seniors’ health behavior and health outcomes in Mexico. The policy implications of the findings have been discussed.
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CHAPTER I

INTRODUCTION

This research examined the health care related issues of the American seniors retiring in Mexico. South American countries, especially Mexico have become one of the most popular destinations for the American retirees during the last few decades. (Sunil, Rojas, and Bradley, 2007; Truly, 2001; Warner, 1997) One of the major complaints of this retired American seniors is that in Mexico they do not get the benefits of Medicare Part B. Medicare does not pay for medical care outside of U.S (Migration Policy Institute, 2006; Warner & Jahnke, 2001). This study was conducted to (1) understand the barriers the US retirees face in Mexico when they need health services; (2) suggest policy implications to increase access to medical care; and (3) add knowledge to the existing literature where not much known about health behavior of US retirees in foreign countries. This chapter provides a description of the problem, justification of the study, and a brief introduction of the theoretical model and research methods.

Extent of the Problem

The United States, like other industrialized nations is witnessing a sharp increase of elderly population. Whereas in 1970 there were 20 million Americans over 65 (1 in 10), in 2000 there were 35 million older Americans (1 in every 8) (US Census, 2001). Mainly due to the increase of life expectancy and the aging of baby boomers, the “graying of America” is predicted to continue for the next several decades. According to US Census Bureau (2007), The US population age 65 and over is expected to double in size within the next 25 years. By 2030, almost 1-out-of-5 Americans will be 65 years or
older. The oldest-old or those aged 85 and over is now the fastest growing age group of the US population.

One of the major problems that elderly people confront after retirement is the lowering of income. Given the fact that they have no means of increasing their income and on the other hand having greater needs for health care, many retirees experience economic deprivation. Therefore retiring in a country where living expenses are considerably cheap is becoming a preferred option to some. In recent years, US retirees are increasingly heading to Latin American countries. Among these, Mexico is probably the most popular destination for the US retirees (Figure 1). According to the Migration Policy Institute (2006), between 1990 and 2000 there was a 17% increase of US born senior citizen residents in Mexico. In some established expatriate retiree communities like Chapala and Los Cabos the growth was incredibly sharp (Chapala 581.4%; Los Cabos 308.3%; San Miguel de Allende 47.7%).

Since US Immigration and Naturalization Services does not keep track of the emigrants, no accurate data is available on US international migrant retirees (US Census Bureau, 2003). Census Bureau has tried only to guess and estimate, and the figure for elderly migrants is totally based on speculations and assumptions. According to Social Security Administration, in 2003 there were a total of 48,328 beneficiaries of Social Security in Mexico. Among them 23,302 were retired workers, the rest are disabled workers, widows, wives, husbands, and children (Social Security Administration, 2004). However, this number of Social Security beneficiaries does not reflect the actual number of retirees in Mexico. Many retirees use addresses in US to receive their checks, and many are seasonal migrants. According to US State
Department the number of Americans in Mexico is over 500,000. (Dallas Morning News, 2005). Some believe that the actual number of Americans living in Mexico is between 600,000 to 1 million, and the overwhelming number of this population is retirees (AHEC, 2005). Some report that over one million retirees from USA live in Mexico. According to a conservative estimate some 100,000 American retirees live in Guadalajara/Chapala/Ajijic area alone. Due to the unofficial nature of the source it is difficult to accept such statistics without any doubt. Therefore, the exact number of Americans living in Mexico is a subject of debate.

The US retirees who immigrate to Mexico are not a homogenous group. Two groups are more likely to migrate to Mexico: the baby boomers, and the Mexican-American retirees (Institute of Migration Policy, 2006; Warner & Jahnke, 2001). As the 35 million baby boomers are moving to retirement age (Population Bulletin, 2002), the number of senior Americans retiring in Mexico is going to increase sharply. Hispanic Americans are more likely to return to Mexico after their retirement.

The major challenge for the US retirees in Mexico is access to health care. Since Medicare Part B does not cover health care expenses incurred in Mexico, retirees have to make periodic trips to US to receive routine and non-routine outpatient services that are covered by Medicare Part B. Also, to continue Medicare Part B coverage, they have to contribute a monthly premium. (Social Security Administration 2008; Warner & Jahnke, 2001) The other sources are private insurance, out-of-pocket payment, or the Mexican Governments insurance plan – IMSS (Instituto Mexicano del Seguro Social). This insurance has no age restrictions and costs only a few hundred dollars. The
problem is it does not cover people with prior chronic conditions such as diabetes or heart disease.

The first cohort of baby-boomers is going to retire soon. With the increase of international retirement migration, it is expected that many of them would choose a foreign nation to retire. It is, therefore, important to know about the US senior citizens' international retirement migration experience, and more specifically how do they deal with their health care issues in their host countries?

Justification for the Research

One of the most important demographic phenomena in the United States in the coming decades will be the huge increase of retired persons as the 35 million baby boomers are moving to retirement age. One of the most pressing concerns for the aging population is the health care issue. Scholars and policy makers are concerned about the future of our health care system regarding the increased burden on Social Security, Medicare, and Medicaid due to growing elderly population (Mechanic, 1999). The retirees traditionally depend on two sources for their health care: Medicare and Retiree Health Insurance (RHI) which is provided by the employer (Eibner, Zawacki, Zimmerman, 2007). However, only a fraction of the retirees are covered through RHI. According to a Kaiser Family Foundation Study (2006), 35% of large firms (employee over 200) offered health benefits such as coverage to their FORMER employees.

A recent Gallup Poll suggests that a majority of the American public are concerned about the projected shortfall of the Social Security Trust Fund (Gallup Poll, 2005). Many elderly with low-income are afraid that they will not be able to afford retiring
due to the rising living and health care expenses. In this context, elderly people in increasing number are shopping around for an affordable place to live after retirement. Researchers predict that Latin American countries could become a popular destination for retired Americans (Burns, 2001; McGraw, 1995; Mead, 2005; Otero, 1997; Warner, 2001). Not only the baby boomers, the elderly Mexican-Americans’ “return migration” will also contribute to this new retirement migration trend.

At individual level, the factors that contribute to the decision to migrate upon retirement might range from climate to financial reasons. At national level, there are concerns about the ability and willingness of society to support the aging population in future. The projected increase of elderly population will necessitate increases in government spending for health care and other social services (Bureau of Labor Statistics, 2004; Wright, 2005). It is projected that starting from 2017 benefit payments will begin to exceed Social Security’s tax revenues. The Trust Fund will be exhausted in 2040 (Trustees Report, 2006). The Social Security Trustee Report (2006) predicts that the projected growing deficits in both Social Security and Medicare will be accompanied by increased revenue financing requirements for Medicare Supplementary Medical Insurance (SMI). Therefore, pressure on Federal budget will intensify.

In this context, retirees’ migration to a foreign country might have positive consequences for the United States since government might be relieved from the costs of some social services. On the other side, because of lower cost of living in those foreign countries retirees’ social security checks would stretch further. This research is valuable because it examined health care issues- the major obstacle that most retirees are concerned of in making their retirement decision to migrate to a foreign land. This
research will contribute to the existing knowledge of gerontology, sociology of health and illness, and social demography through increasing our understanding about the medical care access for US seniors in Mexico. Also, insurance companies may use the findings of this study to modify and extend their coverage policy to include the US retirees in Mexico.

Research Questions

The major research question of this study was: How do the American retirees deal with health care issues in Mexico? The specific research questions that were addressed include: (1) what are the demographic, socio-economic characteristics of the seniors’ decision who migrate to Mexico? What are their motivations to migrate? (2) Which factors affect the health care utilization of the retirees? (3) What are the barriers they face in utilizing these options? (4) How do the health care issues vary by age, income, and health conditions of the retirees?

Theoretical Framework and Hypotheses

This study draws on Andersen’s behavioral model. According to this model, health service utilization can be predicted based on three sets of factors which are predisposing, enabling and needs factors. For retirees, health behavior and health outcomes were measured by three factors: (1) their perception of the Mexican health care system, (2) whether they make trips to US for health care, and (3) their perceived health status. Respondents who identified the health care in Mexico as excellent, and/or do not make trips to US for health care, and/or perceive their health status as excellent
are considered in this study as “satisfied with health care.” The independent variables included predisposing factors (age, gender, and education), enabling factor (income, whether they use Medicare, and whether they perceive any barrier to access care), and need (whether they have any chronic health conditions).

Seven hypotheses were tested to predict seniors’ health care utilization and health outcomes. These are:

H₁: Age is a predictor of US seniors’ health behavior and health outcomes. Seniors over age 65 are likely to be less satisfied with the health care in Mexico.

H₂: Gender is a predictor of US seniors’ health behavior and health outcomes. Males are likely to be less satisfied with the health care in Mexico.

H₃: Education is a predictor of US seniors’ health behavior and health outcomes. College graduates are likely to be less satisfied with the health care in Mexico.

H₄: Income is a predictor of US seniors’ health behavior and health outcomes. Seniors with higher income are likely to be less satisfied with the health care in Mexico.

H₅: Using Medicare for health coverage is a predictor of US seniors’ health behavior and health outcomes. Seniors who use Medicare are likely to be less satisfied with the health care in Mexico.

H₆: Retirees’ perceived barrier to health care access is a predictor of health behavior and health outcomes. Seniors who report at least one barrier in accessing care are likely to be less satisfied with the health care in Mexico.

H₇: Chronic health condition is a predictor of seniors’ health behavior and health outcomes. Seniors who has chronic conditions are likely to be less satisfied with the health care in Mexico.

Research Methods

Data of this study were collected through in-person questionnaire surveys and in-depth case-studies. The sample was selected through purposive sampling technique. Andersen’s behavioral model was used as the theoretical framework. Data were processed through SPSS. Since the variables were nominal, binary logistic regressions
were estimated to test the hypotheses. Three models have been tested for each of the three dependent variables. In model 1, the dependent variable was regressed on the predisposing variables. In model 2, enabling factors were added. Finally in model 3, the need factor was added. Additionally, major patterns and themes were analyzed from the case studies.

Limitations

This study used primary data collected from the field, and therefore is not completely free of some of the limitations that are common to qualitative research.

First, one of the major challenges for this study was to ensure validity and reliability of the questionnaires. A pretest was conducted to increase reliability. The test-retest method was used to examine reliability of the questionnaire. To ensure validity of the measures of the concepts, content validity was considered. The questionnaire was constructed with both close-ended and open-ended questions. For close-ended questions, efforts were given to make the response categories exhaustive and mutually exclusive.

Secondly, the sample of this study was drawn by snowball or purposive sampling techniques. Due to the unavailability of a sampling frame, a probability sample could not be drawn. Therefore there are some concerns regarding the generalization of the findings.

Thirdly, lack of research on the topic was another issue that constrained the formulation of hypotheses. There is no systemic study on this migrant retiree population.
Information of demographic and other socioeconomic characteristics of this population is still not known clearly.

Finally, the sample size of this study was small. As a result, generalization based on that study would be difficult. The findings should be interpreted carefully.

Despite the above limitations, this study generated valuable information on the socioeconomic and demographic characteristics of the US retirees in Mexico. Due to the semi-structured nature of the questionnaire, this research was able to explore many new themes and issues unknown to previous researchers.

Plan of the Dissertation

This dissertation is organized in 6 chapters. Chapter 1 provides an introduction to the study where the extent of the problem and justification of the framework, hypotheses, variables, research methods, and limitations of the study. Chapter 2 explains the theoretical framework of this study, followed by the review of literature. Chapter 3 describes the methodology of the study. Chapter 4 presents the findings of the study based on descriptive statistics and regression results. Chapter 5 provides a discussion of the findings. Finally, Chapter 6 includes conclusion, and policy implications.

Summary

This study examined factors that affect health care utilization of US retirees in Mexico. It is speculated that approximately 600,000 to 1 million US retirees live in different cities in Mexico, and this trend to retire in a foreign land is increasingly
becoming popular. Therefore, an understanding of the health service utilization behavior is critical for both the policy makers and the health industry in regard to provide quality of care to this population. Andersen’s behavioral model for vulnerable population was followed in this research to examine the US senior citizens' health care related issues in Mexico.
CHAPTER II
THEORETICAL FRAMEWORK AND LITERATURE REVIEW

Demographers have long been asking the question, why do people move? While a vast amount of literature is available on the migration patterns of the general population, there is not much literature on why the elderly people move, and more specifically there is only a few research that addressed the question, why do elderly people move to foreign countries? Perhaps research on this topic is severely lacking because of the newness of this type of elderly migration. But the increasing popularity of this elderly international migration lately is drawing the attention of gerontologists, sociologists, as well as policy makers.

The handful of research that is available on the elderly international migrants are focused predominantly on understanding their decision making process and their experience as a whole in changing the destinations. In the absence of relevant work focusing on health care issues of those migrant retirees, the current study faced some difficulty in basing the hypotheses on any firm theoretical framework. Since this current study was about elderly population’s migration and health services utilization, the hypotheses were guided by both the theoretical models from migration literature as well as from health services utilization literature. Typology of elderly migration developed by Litwak and Longino (1987) is still cited widely by most works on elderly migration. This typology provided guidance in research question and hypotheses development in this study. A theory on health services utilization of vulnerable populations has been used in this study to examine the hypotheses of this study.
This chapter describes the theoretical framework, literature review, and the model of this study. In the first section of this chapter the theoretical framework for this study has been discussed. The next section examines previous research on retirees’ health behavior. Finally based on the theoretical framework and existing knowledge, a theoretical model for this present study has been developed.

Litwak and Longino: Typologies of Elderly Migration

To understand what motivates migration at different stages of old age, Litwak and Longino’s (1987) developed a typology of elderly migration. This was a pioneer work on later life migration. They applied the life course model and suggest that older people move because of the institutional pressure resulted from the modern technology and kinship structures. They identified three types of move that reflect the changing conditions at different stages of life-course. Based on their typologies elderly migrants could be categorized into three major groups:

Amenity-seeking migrants: The first type of move is “amenity” migration that happens early in retirement for a small minority of retired persons who are in good health and affluent. They make the decision to migration based on the social and environmental amenities of the host communities. The pull factors to the amenity seekers are recreational opportunity, scenic beauty, pleasant climate, friendly culture, lower crime rates, and lower cost of living. Litwak and Longino describe that this type of move tend to predominate in interstate migration streams. The amenity-seekers are more likely to move from the northern states to the Sunbelts and from the nonmetropolitan to the metropolitan destinations.
**Assistance-seeking migrants:** The elderly are likely to make the second type of move in the face of widowhood and/or moderate disability. They migrate to a place closer to the younger family members since they need help due to chronic disability or widowhood. The “assistance” seekers are comparatively older than the “amenity” seekers. This move is usually from the Sunbelt to the north or from nonmetropolitan to the metropolitan areas. In some cases, assistance-seeking move might represent a counterstream migration, where the retire goes back to the origin.

**Disability-impelled migrants:** The last and final type of move happens when the older person needs exclusive care by kin or has to go to institutional settings for more severe form of disability.

Wiseman and Roseman (1979) developed a similar typology of elderly migration based on their decision making process. Their typology includes both local move and migration. They describe three types of migration move: movement to amenity, return migration, and kinship migration. “Movement to amenity” is the type of migration where the elderly people plan about this well before retirement. The push and pull factors involve environmental stress, reduced difference in the middle class lifestyle between suburban and urban location, increased income, and so on. Decision for this type of migration involves vacation experience, or knowledge about the retirement communities in the destination. Usually married couples make this type of move.

The second type is “return migration” which is more common among the less affluent, and single older people who move after loss of a spouse or deteriorating health condition. The third type is “kinship migration” which is characterized by the elderly people’s motivation to move primarily by the perceived need of assistance due to
declining health condition. Older people move closer to their children, sometimes with a kin, or followed by few years to institutions.

These typologies were developed to describe the elderly migration which was predominantly interstate or domestic in nature. However, the patterns of move and the decision making process described by these typologies might not apply fully to the international migration among the elderly around the world. There is a general perception that the retirement migration of US retires to overseas be “amenity-led” migration and that the retirees are simply motivated to move because they anticipate a pleasant and enjoyable lifestyle in the destinations. This perception is grounded in a large body of migration literature (Bruce, 1996).

Some recent research on the international migration of the senior citizens, however, challenge that seniors mostly migrate for amenities. A report from Institute of Migration Policy (2006) challenged the conventional assumption that retiree migrants are “amenity-seekers.” This report argues that most of the retirees make their decision to migrate to countries like Mexico and Panama mainly in order to be able to afford basic needs. The ‘pull’ factors that affect decision-making process of the seniors to retire in Mexico are low cost of living, affordable live-in help, climate, and pleasing culture. On the other hand, the strongest ‘push’ factor is the higher living cost that they cannot afford in US with the limited income in old age (AARP, 1999; McGraw, 1995; Sunil, 2007; Truly, 2002). Litwak and Longino’s “amenity-seeker” retirees historically have been the elite and affluent population. But for many of the baby boomers who do not have enough money might choose Latin American countries, more specifically
Mexico, mostly due to financial reason (Hass & Serow, 2000). The following section describes the theoretical framework of this study.

Theoretical Framework

Various theoretical models have been developed to explain health services utilization. Among them Andersen's behavioral model which was initially developed in 1960 and subsequently revisited and modified in different phases, is perhaps the most widely used one (Andersen & Newman, 1973; Andersen, 1995). According to Andersen’s behavioral model, individual characteristics, social structure, health care system organization, resources, and needs influence health care services utilization. Originally developed in the 1960s, the behavioral model argues that health service utilization is determined by three factors: predisposing, need and enabling factors. The predisposing domain includes demographic characteristics, such as age, gender, and marital status; health beliefs; and social structure. The enabling domain includes personal/family resources, such as regular source of care, insurance status, and income. Community resources include residence, region, and health services resources, such as volume (physician-population ratio, hospital-bed-population ratio), distribution, financing, price, entry, structure, and process of care. The Need domain includes self-perceptions (perceived need) and objective evaluations (evaluated need) of general population health conditions.

The original model has been modified over the last few decades. In the 1970s, in Phase 2 of this model, environmental variables (healthcare delivery system, external environment, and community) were added (Andersen & Newman, 1973). Healthcare
delivery system variables include policies, resources, organization, and financial arrangements influencing the accessibility, availability, and acceptability of medical care services. External environment includes economic climate, relative wealth, and politics, level of stress and violence, and societal norms. Community level enabling factors refer to the availability of providers in the community where the individual lives. In the third phase, feedback loops were added, which implies that there are reciprocal relationships among the domains (Phillips, Morrison, Andersen, & Aday, 1998).

Andersen's behavioral model for vulnerable populations is based on the assumption that “the factors that make homeless and other populations vulnerable might also affect their use of health services and their health status” (Gelberg, Andersen, & Leake, 2000, p. 1276). Vulnerable populations include minorities, children, elderly, mentally ill, chronically ill, disabled persons, undocumented immigrants, homeless persons, and the impoverished. The behavioral model for vulnerable populations has two domains: traditional and vulnerable. When applied to vulnerable population, both these domains should be included in the model. While traditional domain focuses on the general characteristics of the population, the vulnerable domain is focused on the social structure and enabling resources. The behavioral model for vulnerable population is specifically important to understand senior retirees’ health care utilization because this group is at higher risk of experiencing poorer health compared to the younger counterpart, and also facing higher premium of insurance and financial hardship if they are in any major medical expense (Davis, 1996). This model has been used to understand elderly population’s use of long term services (Bradley & Andersen, 2002); influence of organizational changes on the elderly population’s use of services
Regarding long term care, two types of support care is usually required: assistance with instrumental activities of daily living (AIDL) and assistance with physical activities of daily living (ADL). Elderly who live beyond 75 or 85 years of age are at greater need of services as they are more likely to become frail at some point (Knickman & Snell, 2002).

According to Phase 4 of his model, the health care system (national health policy, resources, and their organization in the health are system) influences the need, predisposing and enabling domains, and also determines uses of services. Research indicates that like the general population elderly people’s health service utilization is similarly affected by need, predisposing, and enabling factors (Wan & Greg, 1983; Wollinski & Coe, 1984).

Review of Literature

Why do retirees migrate to foreign countries?

International retirement migration (IRM) has become a popular trend around the world (Cribier & Kych, 1993; William & Hall, 2000). In Europe, the major trend of international retirement migration is migration from northern to southern Europe. Italy, Portugal, Greece and Spain have seen an increase of international migrant retirees. Among them especially Spain has become one of the most popular destinations for the international retiree migrants (Casado-Díaz, Kaiser, & Warner, 2004; Gustafson, 2008; Hardill, Spradbery, Arnold-Boakes & Marrugat, 2005). A majority of these migrations are “amenity-led” where seniors move because the destination seems to have many leisure benefits and oriented to improve the quality of their lives (Casado-Diaz, 2006).
Figure 1. Andersen's model, Phase 4.

Figure 2. Andersen's behavioral model for vulnerable population

Williams, King, Warner and Patterson (2000) discussed four major reasons for the growth of IRM. First, the increase of longevity and the second is the change of retirement age (or increase of early retirement). Due to these two factors a growing number of people anticipate working longer and entering into the “third age.” Third is the increased flow of lifetime income and accumulation of wealth which also provides a wide variety of retirement options and strategies. Fourth is the increased knowledge and information about foreign countries and experience of visiting them.

The international migrants’ socio-economic backgrounds vary widely based on their national origin and also their retirement destination. Casado-Diaz in his survey found that the migrant retirees background differ significantly by their origin of country. For example the German retirees in Spain were significantly younger than the British, and the British reported higher levels of education compared to the Germans. He also found that the socio-economic backgrounds of the migrant retiree from the same country varies further based on which part of Spain they have chosen to live.

The triggers of decision to migrate have been the focus of attention to demographers and economists. Dwyer (2000) through qualitative interviewing identifies five loose clusters of triggers that are behind the motivational decision of the EU retiree migrants. These are economic issues such as work, lower living cost; family issues such as proximity of family, domestic care, marriage effect; and welfare state issues such as health care services. The last two clusters include life course issues such as wish to be buried ‘at home’; and regional issues such as regional appeal, climate, and so on. Among these triggers, Dwyer found that health care is a strong and recurrent theme in decision making. The climate is not always the most important factor in the decision to
overseas migration. King and Patterson’s (1997) survey on the British retired migrants in Tuscany shows that the retirees move to Tuscany was influenced by a variety of factors, such as work and family links, antipathy to UK, and a positive image of the culture in Tuscany.

The determining factors of migration decision also vary based on the age group of the elderly. The older elderly leave the origin of state to avoid high cost of living, income, and property tax, whereas the younger elderly migrate to states with warmer climate, favorable government policies regarding income tax and welfare spending (Conway & Houtenville, 2003; Hass & Serow, 2000). Health might be another determining factor in retirement migration decision. While health might deter the older retirees from moving, younger retirees might move because their health is still good (Patrick, 1980). While Litwak and Longino emphasized on family ties and health condition in determining the types of move, in a later study Longino, Jackson, Zimmerman, and Bradsher (1991) suggest that income might have a buffering effect on this relationship.

Because international retirement migration is a very recent phenomenon, there is paucity of research on the social and health care issues that the migrants encounter in the country of destination. Migration literature consistently shows that geographic moves involve a lot challenges. Elderly who are closely ties to their preretirement location are less likely to move, and if they move they find it difficult to develop attachments to their new location (Cuba & Hummon, 1993; Hardill, Spradbery, Arnold-Broakes, & Marrugat, 2004). But most retires once they move report very high satisfaction with the new place (Longino, Perzynnsky, & Stoller, 2002; Sunil, 2007).
International migration varies in many aspects from the internal or domestic retirement migration. In terms of domestic migration, in the year 2000, Nevada, Florida and Arizona became the dominant destinations, New York and California became the dominant origin or sending states. For the interstate elderly migrants, the quality of life in the destination was an important determinant (Longino & Bradley, 2003).

While Litwak and Longino (1987) observed that the internal migration of the older population to the Sunbelt is accompanied by a smaller counter stream in the opposite direction. That is, some older migrants decide to move back to their origin states. Stoller and Longino (2001) argue that counter stream move is more likely to occur to those migrants who have support resources and strong ties in the back home community or place of origin.

Golant (1990) analyzes US Census and Current Population Survey data and found trends of metropolitanization and suburbanization among the elderly population. His findings indicate that elderly population compared to younger population is more likely to live in residential areas that are less segregated, and also in metropolitan areas. The reasons for moving to near metropolitan areas include part time opportunities in cities, and desire to live near the metropolitan homes of the children. Florida, California, and Arizona are the states for major destination of US retirees. However, social class interact with the type of elderly different states receive. While Florida and Arizona attract the wealthiest elderly retirees, Texas and California receive the needy and dependent migrants (Biggar, 1984).
Sunil, Rojas, and Bradley (2007) in a qualitative study found that the retirement migration of US seniors differs in nature from the European international migration. While in Europe, retirees migrate from a developed to another developed country, the US retirees migrate from a developed to a developing country. Cost-of-living or financial reasons are the major motives while climate definitely play a role in addition to that. Their findings suggest that US retirement migration replicates many features of the domestic retirement migration in terms of the socio-economic profile and state of origin of the retirees.

Stokes (1990) in his ethnographic study describes the US retirees in the resort zone in the mountains of west central Mexico as ranging from near-poor to affluent and predominantly married couples. He claims that the first retirees to settle in this area were military pensioners, who arrived in the early 1950s. Later arrivals were from different occupations including business executives, entrepreneurs, performers, educators, lower level white color workers, and civil servants. Banks (2004) in his ethnographic study in the Lake Chapala Riviera region, notes that in the last two decades clusters of gated communities called *fraccionamientos* have increased dramatically, where exclusively the American and Canadian retirees live. Banks focuses on how the retiree Americans manage their personal identity in the Lake Chapala area. He uses in-depth interviews and videos, and applied concepts from narrative gerontology to understand this issue. His findings demonstrate that the retirees have both positive and negative perceptions about the Mexican population. Although they describe the host population as friendly, happy, helpful, polite, and enterprising, the
retirees hold negative attitude about trustworthiness and competency of the host population.

Truly (2002) interviewing local real estate agents in the Chapala area was reported a 30-40% increase of short and long-term rental demand in the Chapala area between 1994 and 1997, and construction of new gated subdivisions or fraccionamientos. Truly (2001) focuses on the US retiree migrants' behavior and the impact the migrants are having on the host country. He observes that the retirees who have been migrating in the last few years exhibit different attitudes and behaviors. They also are having a noticeable impact on the culture and society of the area they reside. Though surveys and qualitative interviewing of 258 retirees and local real estate agents in the Lake Chapala area, Mexico, he argues that the 'new' migrant retirees are "importing a lifestyle' in the area they are concentrated. More gated communities are being created for them which are further away from Mexican villages. The new homes are also more modern in terms of appearance and amenities. While the 'new' migrants prefer less interaction with Mexican culture, the 'traditional' migrant group chose to accept and adapt to Mexican culture.

Health care issues.

The biggest challenge for international migrant retirees is probably accessing the health care services (Dwyer, 2000). For instance, within Europe as EU migrants, the elderly can export their right to health care or their “sickness insurance” to the host country and receive similar rights from that country. However, this arrangement has become complicated by the various policies and regulations of different countries.
(Hardill, Spradbery, Boakes, & Marrugat, 2004). For Canadians retiring abroad, the major obstacle is losing the provincial health coverage. Provincial health care programs terminate eligibility after periods of prolonged absence from Canada; typically this period is six months. To maintain health care coverage retirees have to be physically present in Canadian province of residence for 183 days of each calendar year. When retirees stay abroad longer and lose the provincial health coverage, they are required to have replacement coverage, which is not only very expensive but also offers limited benefits for pre-existing conditions (Canada Consular Affairs, 2005). Migrants’ attitude towards the health care system in the host country also affects the utilization of health services. Casado-Diaz (2006) found that retirees have a negative attitude towards using the public health services in the destination area. In his survey he found that migrant retirees in Spain prefer private insurance over public health services.

The US experience might be distinct from that of the European and Canadian elderly migrants. Medicare does not pay for medical care outside of U.S (AARP, 2005; Warner & Jahnke, 2001). The Institute of Migration Policy (2006) reports that the majority of US seniors in Mexico use private medical facilities. Through analyzing Census, and data from their 17 interviews and 9 focus groups, this Institute found that only 37% of US seniors have some sort of health insurance. Some of them have insurance through Mexican social security system, which is called Instituto Mexicano del Seguro Social (IMSS). Although this report provides an overview of US seniors in Mexico through statistics, the retirees’ perception of the health care services and the factors that contribute to the utilization or non-utilization is lacking in this report.
Researchers of Lyndon B. Johnson School of Public Affairs, University of Texas Austin surveyed US retiree citizens in Mexico and found that the respondents on average are not affluent (Warner, 1999). The low cost of living is the major motivating factor for migration. Their study shows that US senior citizens face many barriers in accessing quality health care. As a result many of them return to US sooner than they planned because of their deteriorating health condition. They identified several problems that the US seniors have to deal with regarding health care services utilization in Mexico:

1. Except a few places along in Mexican and Canadian border, and Alaska, and also except limited circumstances, Medicare does not pay for services outside of United States.

2. Although Medicare does not pay for the services, to retain their Part B coverage they have to contribute a monthly premium. If they discontinue the premium, it increases by 10% next time they join. Also, retirees have to make periodical trips to US to receive routine and non-routine outpatient services that are covered by Medicare Part B. This trip is costly and often difficult to afford.

3. They retirees are not eligible for Medigap either as Medigap covers emergency services used during travel or less than 60 days’ stay abroad.

4. US seniors also have problems getting private insurance, because for persons over 65 there are many restrictions.

5. Retirees may sign for IMSS (Instituto Mexicano del Seguro Social) plan. This insurance has no age restrictions and costs only a few hundred dollars. The problem is it does not cover people with chronic conditions such as diabetes or heart disease. So, many people pay out of pocket for office visits and hold insurance in reserve for catastrophic situations (AARP, 2003; Garrett, 2005; Warner & Jahnke, 2001).

Warner and Jahnke (2001), therefore suggest that making Medicare portable could solve this problem. The research conducted by David Warner and his center is the pioneering in addressing the health issues of US seniors in Mexico, but more work is needed to understand the role of Medicare in determining their satisfaction, and their
perceived health condition. Also, it is important to see when the retirees make trip to US due to health care needs, which factors trigger or play role in this decision? In addition, how do all these relationships and influences vary by US seniors' socio-economic background?

Theoretical Model for this Study

This study draws heavily on Andersen's behavioral model for vulnerable populations (Andersen, 1995). This study hypothesizes that health behavior and outcomes of US retirees in Mexico could be explained by the retirees' predisposing, enabling, and need characteristics (Figure 3). According to Andersen's model, characteristics such as age, gender, marital status, ethnicity, education, employment, social networks, occupation, and religion affect individual's health services utilization. For this research age, gender, and education were examined as predictors for the outcome variables which are trip to US, satisfaction with health care system, and perceived health condition. It is expected that for the US migrant elderly population, age would be an important factor in their health care needs and utilization of services. Gender would be another important predisposing factor as health services utilization research show that the use of health services is different for men vs. women (Murphy & Hepworth, 1996).

In Andersen's model, enabling factors are regular sources of care, insurance, income, social support, perceived barrier to care, and community resources. For retirees, enabling factors would be financial resources, Medicare coverage, and perceived barriers to access services. Need factors are perceived and evaluated health
conditions in Andersen’s model. For retirees, need factors would include chronic conditions.

In Andersen’s model, health outcomes are measured by general satisfaction, technical quality, interpersonal aspect, coordination, communication, financial aspects, time spent with clinician, access/availability, convenience, continuity, comprehensiveness, and administrative hassle. The current research focused on three of these outcome variables: retiree’s perception of the healthcare available in Mexico, trips to US for health care, and perceived health status (Figure 3).

This current research hypothesized that US senior citizens’ health care utilization (indicated by level of satisfaction with the healthcare in Mexico, perceived health status, and trips to US for healthcare) are determined by their age, gender, education, income, Medicare use, perceived barriers, and chronic health conditions. Seniors who are satisfied with healthcare in Mexico would more likely to report health care in Mexico as excellent, and less likely to make trips to US for healthcare, and perceive their health as excellent.
CHAPTER III

DATA AND METHODOLOGY

The purpose of this study was to explore how the U.S senior citizens deal with their health care issues in Mexico. There is no secondary dataset available directly on the US retirees’ health. For primary data a purposive sample was drawn utilizing snowball technique. Data were collected from a total of 80 US senior citizens using a semi-structured questionnaire. In addition to this, three case studies were conducted to get an in-depth understanding of the collected data. This chapter provides a description of the study variables, data collection and analysis techniques.

Sample

The study population was the migrant US senior citizens from the USA living in different cities of Mexico. Data were collected from State of Jalisco, Mexico (primarily in areas near Guadalajara, Chapala, and Ajijic), where a large number of international retirees live.

In absence of any official list of the international retirees in Mexico, this study used a purposive sampling technique. In those areas of Mexico, there are some clubs for the retired persons where the members are predominantly senior persons from different nations. Since the focus of this study was US seniors, the sample was consisted of only the U.S seniors. An US expatriate who has been living in Guadelajara since 1998 participated in this study as a key informant. He is a member of the Lake Chapala Society, which is a voluntary association of retirees and claims to have 3,800 members from 24 nations who live in the Lake Chapala area. He administered a total of
100 questionnaire surveys to the members of this club based on his convenience. He was able to get back 80 completed surveys.

Data Collection

Analysis of this research was predominantly based on first hand data collected from the field. Questionnaire surveys and in-depth case studies were used as data collection techniques. The questionnaire included both open-ended as well as structured questions, and was pre-tested. It included questions on respondents’ general demographic and socio-economic characteristics, migration related questions, and health condition and utilization related questions. A total of 80 completed questionnaires were collected over a two-month period. In addition, three case studies were conducted. The cases were identified through snowball sampling technique. All the three respondents that were contacted for case study participated very enthusiastically.

The Variables

Dependent variables.

To understand respondents’ satisfaction with healthcare available in Mexico, three dependent variables were examined in this study: perception of the healthcare available in Mexico, trip to U.S for health services utilization, and perceived health condition. An examination of predictors of these three variables will provide a better understanding of the health behavior and health outcomes of US seniors in Mexico. Since these are nominal level variables, they were recoded as dummy variables. The first dependent variable “perception of the healthcare available in Mexico” was
operationalized by the question: How would you evaluate health care options available for you in Mexico? The options were poor, good, and excellent. Since only 4 respondents out of 80 reported “poor,” in order to measure satisfaction this was recoded as poor/good=0, and excellent=1. So, in this study the dependent variable “satisfaction with health care in Mexico” refers to the responses that reported health care in Mexico as “excellent.”

The dependent variable “TRIP to US” was operationalized using the following question “Do you make trips to US for medical care? Responses were “Yes” and “No.” This was dummy coded as “No” = 0, and “Yes” = 1.

The third dependent variable “perception of health condition” was operationalized by the “How would you evaluate your health condition?” The responses were “poor,” “good,” and “excellent.” Since with exception of 2 respondents all responded “good” or “excellent”, this variable was dummy coded as “poor/good”=0, and “excellent”=1.

**Independent variables.**

Guided by Andersen’s behavioral model for health care utilization for the vulnerable population, this research examined how the respondents’ age, gender, education, income, Medicare use, perceived barriers, and chronic health condition affect their health care utilization and health outcomes, such as satisfaction with health care in Mexico, trips to US for health services, and perceived health status.

Respondents’ age, gender, and education were included in the models as predisposing factors. In the original questionnaire, age was categorized as below 65 years, 65-75 years, and 75 and over. Then for analysis, age was dummy coded as
“seniors (65 and over)” = 1 and “non-seniors” = 0. Gender was dummy coded as “Male” = 1 and “Female” = 0. Education was recoded as “college graduate” = 1 and “no college graduation” = 0.

From Andersen’s enabling and vulnerable enabling domains, three factors were used as independent variables. These are income, Medicare use, and perceived barriers. Data on income was collected using an ordinal level variable where respondents were asked to identify their annual income from an income distribution. For analysis, income was dummy coded as high income which was “income US$ 45,000 or over” = 1 and low income which was “Less then US$45,000” = 0. “Perceived barriers” to access was operationalized from the question, “What are the major obstacles you face here in terms of health care? List them according to their importance.” The major responses were (1) Medicare does not cover expenses incurred in Mexico, (2) the hospitals are not near and (3) hospitals lack technologies and equipments. Respondents who reported any of these obstacles were coded into a new variable “Perceived barriers” where 1=”a barrier was reported” and 0= “no barrier was reported.”

Use of Medicare was operationalized by the question “How do you cover your medical expenses?” The options were Medicare, IMSS, private insurance, and out of pocket (no insurance). A new variable was created from this question “Medicare” where 1= “the respondent checked Medicare as an option” and 0= “respondent did not check Medicare as an option”. It is noteworthy that the value “1” in this variable does not necessarily mean Medicare is the only source of coverage. Respondents could have checked only Medicare, or Medicare and a combination of other options.
Only one variable from the vulnerable need domain was used in the analysis, which is chronic condition. Chronic condition was operationalized by the question “Do you have any chronic condition?” This variable was dummy coded as “Yes”=1 and “No”=0.

Statistical Method and Analysis

After completion of data collection, obtained data were checked, verified and edited. For the structured questions on the questionnaire, SPSS was used for data processing. Since the dependent variables were dichotomous, binary logistic regressions were conducted to estimate the models. Three different models have been estimated to test each of the seven hypotheses. In addition, frequency and percentages from the descriptive output of SPSS were used to discover and substantiate patterns and relationships. Case studies were analyzed for major themes and patterns.

Ethical Issues

No personal identifying information was included on the questionnaire. At the beginning of the questionnaire, respondents were given information about the purpose and nature of the study. Respondents were told that their participation is voluntary and that their responses would be kept confidential and anonymous. Since this study involved human subjects, approval from IRB was taken after developing the questionnaire. A copy of the questionnaire and the informed consent form has been attached in the Appendix section.
CHAPTER IV

RESULTS

As stated and documented previously, there is not extensive research on this topic. Therefore, this study was not only limited to examining the hypothesized relationships of the variables, but also attempted to explore the related issues. These included what are the demographics or socioeconomic characteristics of the retirees? Why did they migrate? Are they happy with the decision? Why or why not? This chapter presents the descriptive as well as regression results based on the questionnaire based data.

Profile of the US Seniors

A number of questions were included in the questionnaire to explore the demographics and socio-economic background of the US seniors in Mexico. Respondents were asked about their age, gender, marital status, race, education, occupation, and sources of income. Table 1 presents the demographic and socio-economic characteristics of the respondents.

In terms of race, the US seniors in Mexico are a homogenous group. They are predominantly non-Hispanic Whites. In the sample there were only 4 non-whites, which include non-Hispanic Black (1 respondent), Hispanic (1 respondent), and other race (2 respondents). Most of the US retirees who live in Mexico are over 65 years old and married. Thirty-three percent of the respondents were less than 65 years old. The rest are 65-85 years old. None of them were over age 85. There were more females (51%)
than males (49%). Eighty percent of the respondents are married. The rest are non-married which includes single (4%), divorced (7%) and widowed (5%).

Table 1

*Frequencies of Demographic and Socio-economic Variables*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Responses</th>
<th>%</th>
<th>Frequencies</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Less than 65</td>
<td>32.9</td>
<td>25</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>65-75 years</td>
<td>50.0</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td></td>
<td>75-85 years</td>
<td>17.1</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>48.7</td>
<td>37</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>51.3</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td>Married</td>
<td>84.2</td>
<td>64</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>Single</td>
<td>3.9</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>6.6</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>5.3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>White</td>
<td>94.7</td>
<td>72</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>Non-White</td>
<td>5.3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>College grad</td>
<td>No</td>
<td>45</td>
<td>36</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>55</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td>No</td>
<td>45</td>
<td>36</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>55</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Income (yearly in US$)</td>
<td>Less than 15,000</td>
<td>5.17</td>
<td>3</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>15,000 - 44,999</td>
<td>36.21</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td></td>
<td>45,000 – 74,999</td>
<td>24.14</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>75,000 – 99,999</td>
<td>18.97</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100,000 and over</td>
<td>15.52</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

*Note: The sample size in this study was 80. However, not all respondents answered all items from the questionnaire. As a result number of valid case varies for different variables.*

Fifty-five percent of the respondents had 16 years or more education. About 45% of the respondents were still working compared to 55% that were retired. Those who
work mostly work part time only. And those who do not work are often involved with charitable works or spend their time being members of different clubs.

Fifty-eight percent of the respondents earn on average more than US$ 45,000 or over annually. US seniors have several sources of income. Among these, 70% of the respondents said their income comes from Social Security. Private assets are the source of income for almost 67% of the seniors, followed by savings (46% seniors). Only 6% of them said that wages or salary is one of their current sources of income.

Table 2

*Respondents’ Current Sources of Income*

<table>
<thead>
<tr>
<th>Sources</th>
<th>%</th>
<th>Frequencies</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social security</td>
<td>70</td>
<td>56</td>
<td>80</td>
</tr>
<tr>
<td>Private assets</td>
<td>62.5</td>
<td>50</td>
<td>80</td>
</tr>
<tr>
<td>Savings</td>
<td>46.3</td>
<td>37</td>
<td>80</td>
</tr>
<tr>
<td>Retirement plan</td>
<td>17.5</td>
<td>14</td>
<td>80</td>
</tr>
<tr>
<td>Spouse’s contribution</td>
<td>16.3</td>
<td>13</td>
<td>80</td>
</tr>
<tr>
<td>Salary/wage</td>
<td>6.3</td>
<td>5</td>
<td>80</td>
</tr>
<tr>
<td>Children’s contribution</td>
<td>1.3</td>
<td>1</td>
<td>80</td>
</tr>
</tbody>
</table>

*Note*: Respondents were allowed to check multiple sources.

Reasons for Migration

The respondents' length of stay ranges from 3 months to 26 years. Seventy percent of the respondents have been living in Mexico for more than 5 years. Almost
30% of them migrated there about 10 years ago (Table 2). Although senior citizens in Mexico come from a number of different states, the highest number of them come from Texas and California (13.8% from each) followed by Florida (12.5%). The other states from which the retirees typically come to Mexico include Illinois (7.5%), Missouri, Tennessee, and New Jersey (5% from each), and Minnesota, Washington, Arizona, Kansas, Nevada, New York, Oregon, Wisconsin, Pennsylvania, Connecticut, and Colorado.

Most of the US retirees chose the bordering cities as destination in Mexico. Majority of them live in two cities: Ajijik (65%) and Chapala (16%). A few live in Jocotepec, Chula Vista, San Lois Soyatlan, and Nextipac. Almost 91% of them indicated that they intend to stay there permanently. Only 2 retirees said they are there temporarily while 5 said they have not decided yet.

Warm and pleasant climate was the major pull factor for most of the retirees. In addition to climate, a large number of them indicated that low living cost in Mexico motivated them to migrate here. Many of them also identified culture of Mexico as an attraction for them to move here. Some indicated that a lower medical expense in Mexico was the reason they migrated there.

Most of the respondents feel that their decision to migration to Mexico after retirement was a right one because of the factors such as climate, life style, and cost of living (Table 4). However, some of the things that they expressed frustration about include corruption, noise, non-availability of 911 services, and not having family around. Ninety-one percent of them said that they have retired their permanently while only 6% said they are not sure whether they would move again in future.
Table 3

Reasons for Believing that the Migration Decision was Right (N=77)

<table>
<thead>
<tr>
<th>Reasons</th>
<th>%</th>
<th>Frequencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Climate</td>
<td>86</td>
<td>69</td>
</tr>
<tr>
<td>Low living cost</td>
<td>65</td>
<td>52</td>
</tr>
<tr>
<td>Culture</td>
<td>45</td>
<td>36</td>
</tr>
<tr>
<td>Driving distance from US is short</td>
<td>8.8</td>
<td>7</td>
</tr>
<tr>
<td>Ability to retire early</td>
<td>6.3</td>
<td>5</td>
</tr>
</tbody>
</table>

*Note: ninety-six percent of the respondents believe that their decision was right.*

Table 4

Frequencies of Variables Related to Retirement Destination

<table>
<thead>
<tr>
<th>Variables</th>
<th>Responses</th>
<th>%</th>
<th>Frequencies</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of stay</td>
<td>0-5 years</td>
<td>31.3</td>
<td>25</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>5-10 years</td>
<td>35.0</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10-15 years</td>
<td>28.7</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15-20 years</td>
<td>3.8</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20-25 years</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25-30 years</td>
<td>1.3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Plan to stay</td>
<td>Temporary</td>
<td>2.5</td>
<td>2</td>
<td>79</td>
</tr>
<tr>
<td></td>
<td>Permanent</td>
<td>91.1</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Undecided</td>
<td>6.3</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Decision to move to Mexico</td>
<td>Wrong</td>
<td>1.3</td>
<td>1</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>Right</td>
<td>96.1</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>2.6</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
Almost all the respondents perceive their health conditions as good or excellent. Only 2 of them (2.6%) reported having poor health while 30 of them (out of 78) reported excellent health condition. Almost half of them have at least one chronic condition and have been sick at least for a day in the past 12 months. Only 1 in 5 has any physical disability.

Table 5

*Health Condition of the Respondents*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Responses</th>
<th>%</th>
<th>Frequencies</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived health condition</td>
<td>Poor</td>
<td>2.6</td>
<td>2</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>59.0</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Excellent</td>
<td>38.5</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Sick day in 12 months</td>
<td>0 days</td>
<td>36.8</td>
<td>21</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>1 or more days</td>
<td>63.2</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Hospitalized in 12 months</td>
<td>No</td>
<td>84.4</td>
<td>65</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>15.6</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Chronic condition</td>
<td>No</td>
<td>46.7</td>
<td>35</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>53.3</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Physical disability</td>
<td>No</td>
<td>81</td>
<td>60</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>19</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

Health Care Utilization

The majority are Medicare eligible (70%) and only 54% continue Medicare Part B. For health coverage, they depend on multiple sources (Table 6). Almost one-third of the seniors (27.5%) depend only on private insurance. Almost one-tenth pay their health
expenses out of pocket. Only 2 seniors out of 80 use only Medicare for health coverage. Some of them (6.3%) who use Medicare also have private insurance. Another 7.5% seniors said that they use private insurance and out of pocket payment along with using Medicare. Only one respondent use all these forms of expenses to cover their health costs (Table 6).

Table 7

Frequencies of Variables Related to Health Care Utilization

<table>
<thead>
<tr>
<th>Responses</th>
<th>%</th>
<th>Frequencies</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing Medicare B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>16.3</td>
<td>13</td>
<td>80</td>
</tr>
<tr>
<td>Yes</td>
<td>53.8</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>No answer (Does not apply)</td>
<td>30.1</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Medicare eligibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>29.9</td>
<td>23</td>
<td>80</td>
</tr>
<tr>
<td>Yes</td>
<td>70.1</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>No answer</td>
<td>3.8</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Health care in Mexico</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>13.5</td>
<td>10</td>
<td>74</td>
</tr>
<tr>
<td>Good</td>
<td>51.4</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>35.1</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Trip to US for health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>47.9</td>
<td>35</td>
<td>73</td>
</tr>
<tr>
<td>Yes</td>
<td>52.1</td>
<td>38</td>
<td></td>
</tr>
</tbody>
</table>

Note: Respondents identified multiple sources that they use to cover their medical expenses.

Over half of the seniors make trips to US for health services. Only 14% reported the health care in Mexico as poor while 35% think that the health care in Mexico is excellent. Although the US seniors in Mexico are happy about their stay in Mexico, some of them identified a few obstacles that they face there. They reported many obstacles they face in getting quality care in Mexico. The number one obstacle for them
Table 6

Sources of Paying Medical Expenses (N = 80)

<table>
<thead>
<tr>
<th>Sources</th>
<th>%</th>
<th>Frequencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only private insurance</td>
<td>27.5</td>
<td>22</td>
</tr>
<tr>
<td>Only out of pocket (No Insurance)</td>
<td>11.3</td>
<td>9</td>
</tr>
<tr>
<td>Only IMSS</td>
<td>6.3</td>
<td>5</td>
</tr>
<tr>
<td>Only Medicare</td>
<td>2.5</td>
<td>2</td>
</tr>
<tr>
<td>Private &amp; out of pocket</td>
<td>6.3</td>
<td>5</td>
</tr>
<tr>
<td>IMSS &amp; out of pocket</td>
<td>7.5</td>
<td>6</td>
</tr>
<tr>
<td>IMSS &amp; private</td>
<td>1.3</td>
<td>1</td>
</tr>
<tr>
<td>IMSS &amp; Medicare</td>
<td>1.3</td>
<td>1</td>
</tr>
<tr>
<td>Medicare &amp; out of pocket</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Medicare &amp; private insurance</td>
<td>6.3</td>
<td>5</td>
</tr>
<tr>
<td>Medicare &amp; private insurance &amp; out of pocket</td>
<td>7.5</td>
<td>6</td>
</tr>
<tr>
<td>Medicare &amp; IMSS &amp; out of pocket</td>
<td>3.0</td>
<td>3.8</td>
</tr>
<tr>
<td>Medicare &amp; IMSS &amp; private insurance</td>
<td>1.3</td>
<td>1</td>
</tr>
<tr>
<td>IMSS &amp; private &amp; out of pocket</td>
<td>1.3</td>
<td>1</td>
</tr>
<tr>
<td>IMSS &amp; private &amp; Medicare &amp; out of pocket</td>
<td>1.3</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: Respondents identified multiple sources that they use to cover their medical expenses.
Table 8

*Major Obstacles Related to Accessing Healthcare in Mexico (N = 80)*

<table>
<thead>
<tr>
<th>Responses</th>
<th>%</th>
<th>Frequencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Medicare coverage*</td>
<td>21.0</td>
<td>17</td>
</tr>
<tr>
<td>Hospitals not nearby</td>
<td>15.0</td>
<td>12</td>
</tr>
<tr>
<td>Lack med equipments</td>
<td>15.0</td>
<td>12</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>16.0</td>
<td>13</td>
</tr>
<tr>
<td>Language</td>
<td>16.0</td>
<td>13</td>
</tr>
<tr>
<td>No 911 service</td>
<td>4.0</td>
<td>4</td>
</tr>
</tbody>
</table>

Note: Respondents were allowed to check multiple obstacles.
* Since Medicare does not reimburse for care in Mexico, they can’t use many services that they could use if they were in US.

was the no Medicare coverage in Mexico. Since Medicare does not cover the expenses in Mexico, many of them have to make expensive trip to US Other complains include the distance of hospital/clinics from their residences, lack of medical technologies and equipments in the clinics or hospitals in Mexico. A few of them stated that not having 911 services or not knowing the native language were some of the obstacles to get quality care in Mexico.

Regression Results

Three models were estimated separately for each of the three dependent variables to understand US seniors’ health behavior and outcomes. Three models were estimated to test the hypotheses. In model 1, the three dependent variables were regressed on predisposing variables (age, gender, and education). In Model 2 enabling
factors were added (income, barriers, and Medicare use). Finally in the third Model, a need variable (chronic illness) was included. Regression results of these three equations are presented in Table 9, 10 and 11. The next three sections present the regression results.

_Perception of healthcare available in Mexico._

The first dependent variable considered was respondents’ perception of healthcare. Because there was little variation on this factor, it was dichotomized, with poor through good coded as 0, and excellent coded as 1. In model 1, where only predisposing factors were entered, only education had significant effect on perception of healthcare. Seniors with college degrees are almost five times as likely as those who do not have college degrees, to perceive the healthcare in Mexico as excellent ($p < .01$).

In models 2 and 3, four variables had statistically significant effects on retirees’ perception of healthcare available in Mexico (Table 9). When predisposing, enabling and need factors are taken into account, age, gender, college graduation, and Medicare use were statistically significantly related to perception of healthcare in Mexico as excellent. Model 2 indicates that seniors over age 65 are more likely to report healthcare available in Mexico as excellent compared to those who are less than age 65 (OR = 99.12, $p < .001$). The odds of perceiving healthcare in Mexico as excellent are lower for men than women ($p = .01$). The odds of perceiving healthcare in Mexico as excellent are about 0.058 for those who use Medicare for health coverage than those who do not ($p < .01$).
In Model 3, chronic condition was added. Seniors are still more likely to report healthcare available in Mexico as excellent ($p < .01$) (Table 9). Chronic illness shows no effect on perception of healthcare.

Table 9

*Logistic Regression for Determinants of Retirees’ Response that Healthcare Available in Mexico is Excellent*

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Predisposing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior</td>
<td>2.462</td>
<td>99.117***</td>
<td>84.418**</td>
</tr>
<tr>
<td>Male</td>
<td>.448</td>
<td>.098**</td>
<td>.107*</td>
</tr>
<tr>
<td>College grad</td>
<td>5.279**</td>
<td>98.877***</td>
<td>87.239**</td>
</tr>
<tr>
<td><strong>Enabling</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income&gt;45,000</td>
<td>2.748</td>
<td>2.649</td>
<td></td>
</tr>
<tr>
<td>Medicare use</td>
<td>.058**</td>
<td>.064**</td>
<td></td>
</tr>
<tr>
<td>Barriers</td>
<td>.557</td>
<td>.561</td>
<td></td>
</tr>
<tr>
<td><strong>Need</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic illness</td>
<td></td>
<td></td>
<td>.828</td>
</tr>
<tr>
<td>-2 log likelihood</td>
<td>84.533</td>
<td>43.054</td>
<td>42.831</td>
</tr>
<tr>
<td>Model $\chi^2$</td>
<td>10.540**</td>
<td>28.052***</td>
<td>25.190***</td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>3</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>$N$</td>
<td>73</td>
<td>57</td>
<td>55</td>
</tr>
</tbody>
</table>

† $p < 0.1$; * $p < .05$; ** $p < .01$; *** $p < .001$ (one-tailed tests)

The three models indicate that age, gender, college education, and Medicare use are significant predictors of respondents’ perception of healthcare in Mexico as
“excellent.” On the other hand, income, perceived barriers, and chronic health condition did not show any effect on seniors’ perception of health care in Mexico.

Trips to US for healthcare.

Three models were estimated to examine the predictors of US seniors’ trip to US for healthcare (Table 10). In model 1 where only predisposing variables were included, age had significant effect on seniors’ trip to US for healthcare. Seniors over age 65 are more almost 4 times as likely as those who are less than age 65 to make trips to US for health care ($p < .01$), most likely because of eligibility for Medicare coverage. In fact, in model 2 and 3, when enabling and need factors were taken into account, age was no longer significant but Medicare use had significant effect on trips to US. Those who use Medicare to cover their health expenses are more likely to make trips to US than those who do not use Medicare (OR = 64, $p < .001$), to be expected because Medicare coverage can be used only in the US.

In model 3, with control for chronic condition the effects of Medicare use remain strong (OR= 74, $p < .001$). In this model, chronic condition also was significant associated with trips to US. Those who have chronic conditions are 6 times as likely as those who do not have a chronic condition, to make trips to US ($p < .05$).
Table 10

*Logistic Regression for Determinants of Retirees’ Trip to US for Healthcare Services*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Predisposing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior</td>
<td>3.574**</td>
<td>.771</td>
<td>1.260</td>
</tr>
<tr>
<td>Male</td>
<td>.773</td>
<td>2.645</td>
<td>2.503</td>
</tr>
<tr>
<td>College grad</td>
<td>1.249</td>
<td>1.315</td>
<td>1.978</td>
</tr>
<tr>
<td><strong>Enabling</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income &gt;45,000</td>
<td></td>
<td>2.391</td>
<td>3.196</td>
</tr>
<tr>
<td>Medicare use</td>
<td>64.483***</td>
<td>73.522***</td>
<td></td>
</tr>
<tr>
<td>Barriers to access</td>
<td>1.369</td>
<td>1.325</td>
<td></td>
</tr>
<tr>
<td><strong>Need</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic illness</td>
<td></td>
<td></td>
<td>6.393*</td>
</tr>
<tr>
<td>-2 log likelihood</td>
<td>93.671</td>
<td>47.582</td>
<td>41.311</td>
</tr>
<tr>
<td>Model $\chi^2$</td>
<td>5.920</td>
<td>27.771***</td>
<td>31.235***</td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>3</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>N</td>
<td>72</td>
<td>55</td>
<td>53</td>
</tr>
</tbody>
</table>

† $p < 0.1; * p < .05; ** p < .01; *** p < .001$ (one-tailed tests)

*Perceived health condition.*

To examine the predictors of perceived health condition as excellent, the models were estimated using binary logistic regressions (Table 11). Model 1 indicates that none of the predisposing variables have any effect on respondents’ perceived health condition as excellent. However, in model 2 when enabling factors are added, education became significant predictor of perceived health condition. All else being equal, college graduates are almost four times as likely as those who do not have college degrees, to report their health condition as excellent ($p < .01$). In model 3 with chronic condition added, education still remains significant and its effect shows as stronger. Seniors with
college degree are almost 5 times more likely to perceive their health as excellent compared to those who do not have college degree ($p = .01$). In this model, chronic condition was another significant predictor of perceived health. The odds of perceiving health condition as excellent are about one-sixth for seniors who have a chronic condition compared to those who do not have such a condition ($p < .001$).

Table 11

*Logistic Regression for Determinants of Retirees’ Perceived Health Condition as Excellent*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Predisposing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior</td>
<td>1.141</td>
<td>2.219</td>
<td>2.617</td>
</tr>
<tr>
<td>Male</td>
<td>.488</td>
<td>.626</td>
<td>.467</td>
</tr>
<tr>
<td>College grad</td>
<td>1.984</td>
<td>3.850**</td>
<td>5.281**</td>
</tr>
<tr>
<td><strong>Enabling</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income&gt;45,000</td>
<td>1.060</td>
<td>1.054</td>
<td></td>
</tr>
<tr>
<td>Medicare use</td>
<td>.721</td>
<td>.427</td>
<td></td>
</tr>
<tr>
<td>Barriers</td>
<td>.538</td>
<td>.989</td>
<td></td>
</tr>
<tr>
<td><strong>Need</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic illness</td>
<td>96.636</td>
<td>70.738</td>
<td>56.686</td>
</tr>
<tr>
<td>-2 log likelihood</td>
<td>3.449</td>
<td>6.145</td>
<td>16.345*</td>
</tr>
<tr>
<td>Model $\chi^2$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>3</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>$N$</td>
<td>75</td>
<td>57</td>
<td>55</td>
</tr>
</tbody>
</table>

† $p < 0.1$; * $p < .05$; ** $p < .01$; *** $p < .001$ (one-tailed tests)
Summary of the Logistic Regression Results

The regression results for satisfaction with health care in Mexico indicate that age, gender, education, and Medicare use had significant effects on seniors' satisfaction. Therefore, Hypotheses 1, 2, 3, 5, and 7 are supported. The regression results for trip to US for health care show that when controlled for predisposing, enabling, and need factors, Medicare use and chronic condition are significantly associated with seniors' trips to US for healthcare. Finally, the regression results for perceived health condition (as excellent) indicate that when controlled for enabling, predisposing, and need factors, education and chronic condition are predictors of seniors' report of their health condition as excellent.
CHAPTER V
DISCUSSION AND CONCLUSION

The limited number of studies on US international retirement migration that have been available mostly focuses on the reasons of migration or a few on the lifestyle of those US expatriates. A handful of them addressed the health issues and they all argued that the major obstacle for the US retirees in Mexico is the lack of Medicare coverage. This current research, therefore, focused on this important but under-researched topic to understand the expatriates' behavior related to health care utilization. This chapter presents a discussion of the findings from data collected through questionnaire surveys. Also, recurrent patterns that emerged in through the case studies have been discussed to better understand the questionnaire-generated data.

The data of this research shows that US seniors in Mexico are likely to be non-Hispanic White, most of them are married, educated with college degree and are affluent. Over half of them are retired while the rest work part time. "Most people come here to retire. They keep a little bit of work to keep their mind active and do something."

This study found that almost one-third of them earn US$ 75,000 or more while another one-third earns less than US$ 35,000 annually. Some of them (15%) are quite affluent and reported an income of US$ 100,000 or above annually. The income distribution found in this study is not surprising as Stokes (1990) also reported in his study that the US seniors there range from near-poor to affluent. Banks' (2004) finding is also consistent with this current study’s finding. Banks (2004) observed that the US retirees live in exclusive gated communities. But it is noteworthy that there were only 58
responses on income among the 80 surveys. There is a possibility that only the high
income respondents replied to that question on “Yearly income in dollars”.

The major reasons to migrate are warm climate, low living cost, and pleasant
culture. In addition, the slower pace of life was mentioned by many seniors as a big
advantage of living in Mexico.

Its really like living in paradise. I do not like snow. I don’t like to sweat in a very
humid climate. I don’t like to shovel snow or rake leaves. We have a beautiful
climate, green mountains, and a lake. Humidity is about 20%, temperature is 76°
to 85°. You don’t need an air conditioner, but you do need a heater. We have a
nice pool and we heat it with solar panels. Here the temperature rises upto 90°,
that is very nice. We use solar panels for hot water for the house, too.

Mexico is more social and has a slower pace of life……better climate, the
population is more laid back; their family is much more important to them than
jobs and work, and making the train on time.

Although most seniors surveyed in this study said that climate and culture were
their big attractions for moving to Mexico, almost all of them also reported the lower
living cost as another big reason to for the move. This study, therefore, questions the
popular perception that the seniors’ international migration is nothing but “amenity-led"
move. Amenity-led move refer to the migration of young-old to a destination for better
quality of life and for the recreational opportunities. Many of them are afraid that they
would not have been able to maintain their lifestyle with lowering income in US.

We would have difficulty living in the States considering cost of gas, electricity
and water. Think about what you pay up there vs. what we pay here. So, you can
live a much better life here comparing to US.

Some of them also expressed concerns about rising healthcare costs in US. With
increased health care needs and reduced income, some were nervous to live in US.

You can buy drugs over the counter, you buy them cheaper than here (US) and
the pharmaceutical stuffs are better there (Mexico), and most people pay out of
the pocket. You can get everything cheap there. For example, a knee
replacement will cost $15,000 in Mexico while same thing here would cost $80,000.

It might be possible that while those who migrated earlier, were amenity-seekers, but the motivation of the recent migrants might be different. Recent migrants perhaps would report low-cost of living as the major reason rather than climate or culture. Majority of them had traveled to other countries to spend the vacations, and this experience and exposure to other cultures helped them to make informed decision to move to a foreign land.

Really my wife does not like the cold dark winter weather … we have very bad weather in the northwest (in US) in the winter. And she has traveled quite a bit in Latin America specially Mexico. So she is very comfortable there (Mexico). I think in fact it has a lot to offer as we become senior citizen.

I saw a program on a travel channel. It said the two best climates in the world are one in Kenya and the other in Lake Chapala. I didn’t know what Lake Chapala was. Out of curiosity I drove to Guadalajara in 1990. I thought that Guadalajara is too big. I came down to Lake Chapala. When I decided to retire we came down here. We live in Chula Vista which is up high. We have a beautiful lake, mountains. I always dreamed of living near water and mountains. This is the only place you can do it.

A majority of them continue premium for Medicare Part B though they can have Medicare pay for medical services in Mexico. However, a third of the respondents use Medicare for their expense of health care coverage, which means they use medical care services in the United States. While the survey data shows that overall satisfaction of the seniors with the medical care services that are available in Mexico is high, the case studies indicate a mixed result. Out of the three randomly chosen case studies, one suggest excellent, one good, and the other poor health care in Mexico. We choose three cases and tried to select cases that represent the range of options used
by local American retirees. One case did not basically use local services and another
case was to represent someone who used the Mexican medical care services
predominantly.

For the person who used the Mexican system, the cost and quality of services
and drugs were felt to be much better in Mexico compared to that in US.

Americans, believe it or not, most of the medicines they take are actually made in
Mexico. Pfizer has five large factories in Mexico. Americans mostly take Mexican
medications anyway. It will not specify “Mexican” on the labels.

You just go to his (doctor’s) office. First he will ask you how you are, family and
dog. May be he will invite you for a cup of coffee. He will sit and talk. Then goes
to take a prescription pad and starts writing. He makes a few suggestions. They
are very methodical, easy to get acquainted, and very slow to load you up on a
lot of medicine. They are very easy to talk. Doctors in the United States are on
time clock, you are good for fifteen minutes then the nurse comes in. Here he is
gonna ask you about your family, may be give you a cup of coffee and it's a very
relaxed environment, a whole different attitude.

Although previous studies (Warner & Jahnke, 2001; Warner, 1997, 1999) state
that US seniors are facing many healthcare related problem due to lack of Medicare
coverage in Mexico, this current study found that respondents have different
experiences in terms of dealing with heath care. Not only a big number of them reported
the health care in Mexico as excellent, a few even rated is as better than the US
healthcare. Those who are not satisfied with the Mexican health care, reported many
problems with IMSS. Since IMSS is socialized medicine, there are local clinics that work
as gatekeepers to specialists. People have to wait longtime to get into hospitals. And
those hospitals provide poor quality drugs, do not do the necessary tests, as well as
they have doctors who are incompetent. As a result many seniors that are well of make trip to US for care, and for emergency cases they go to Guadalajara.

Consistent with Warner & Jahnke’s (2001) study, this study also found that many seniors believe that Medicare should be available in Mexico. They feel it would be only fair if they US seniors get Medicare services while they are living in another country as they have paid or are still paying for it.

If you are on vacation you are traveling stumble and fall and break your foreign country. It should at least emergency like heart attack, acute kidney stone, and acute gallbladder duck stone thing like that when you don’t plan those. It’s not like cosmetic surgery such as having a tummy tuck, liposuction, cosmetic surgery. So I think the Medicare ought to cover cost for emergency so people who are either working out of country or who are traveling and visiting. They do not plan to have a heart attack.

The regression analysis of this study shows that seniors’ health behavior and health outcomes are affected by a number of different variables. While age, gender, education, and Medicare use are associated with seniors’ satisfaction with healthcare, Medicare use and chronic condition are associated with seniors’ trips to US for healthcare. Seniors’ perceived health condition (as excellent) is determined by education and chronic condition.

It is interesting to note that seniors over age 65 are more likely to report health care in Mexico as excellent. The reason probably is that many seniors with their increased health care needs feel that they would not be able to afford healthcare in US. At the same time they find from drug to health service fees everything much cheaper in Mexico.

You know in the United States there is a thing called rationed health care. Lots of people don’t know about this. As you get older you are eligible for fewer and fewer procedures. If you go to an emergency room they will not ask your name,
the first thing they will ask you is your age. Suppose you are 68. They have a
book they will turn to that page for age 68, that book tells you what procedures
you are eligible under Medicare. At age 69 you are eligible for fewer procedures,
at age 75 even fewer yet you still pay the same money every month. Most
Americans do not realize this. That rationing does not exist here.

College graduates are likely to report better health compared to those without
college degree. Educated people might have higher income and therefore are able to
pay out-of-pocket or afford private health insurance, and therefore less complaining
about the care available there. Moreover, educated people might have greater access
to printed or online health information and therefore might not feel the necessity of
utilizing formal care as much as those with lower education. Also, it is reasonable that
respondents with a chronic condition are less likely to report better health compare to
those without a chronic condition. Finally, Medicare use affects health behavior and
outcomes as seniors have to make trips to US for the health cost to be covered by
Medicare.

As was found in Sunil et al’s (2007) study, this study also finds that the majority
of the US seniors in Mexico are happy about their decision to move to Mexico. While
Warner and Jahnke’s (2001) study claim that many US seniors return to US sooner then
they planned because of the lack of Medicare coverage there, in this current study
except few, none of the respondent indicated any plan to returning to US due to health
related issues.

I think I am lot better here. I am worried if I go to States and get sick how quick
can I get back to Mexico. I have better care in Mexico than in the United States. I
know it’s hard to believe. But you have to experience it to realize it and eventually
it will soak in.
CHAPTER VI

CONCLUSION AND POLICY IMPLICATIONS

This research examined the health care related issues of the American seniors retreating in Mexico. Although international retirement migration is increasing among the seniors in the United States, not much is known about this type migration yet. There is a lack of research providing the demographics, social, healthcare, and other migration related issues that US international migrant seniors face. This study was conducted with the goal of exploring these issues and more specifically to get an in-depth understanding of the health behavior and health outcomes of US seniors in a foreign country, such as Mexico. Data were collected through in-person questionnaire surveys and case studies. The major findings of this study are presented below.

1. US seniors retiring in Mexico are predominantly non-Hispanic whites, aged over 65, married, and more likely to be college graduates. Many of them are semi-retired and continue to work part time.

2. This study challenges the general perception that US seniors move to foreign countries is “amenity-led.” The case studies clearly show that many US seniors move there because they are afraid that with reduced income and increased health care needs they would not be able to maintain the same lifestyle after retirement in the US. Climate and the slower pace of life are two other big attractions for seniors’ to move to Mexico.

3. Climate is one of the most important reasons that US seniors are heading towards Mexico. Almost all the respondents reported the climate in Mexico as very pleasant.
4. A major finding of this study is age, gender, education, use of Medicare for coverage, and chronic condition are significant predictors of US seniors’ health behavior and health outcomes in Mexico. Seniors over age 65, males, college graduates, those who use Medicare, and those who have chronic conditions are less likely to be satisfied with the healthcare available in Mexico.

Many American retirees in Mexico are there because of the lower cost of living, and although retiring in Mexico may require some resources, such retirees may include those who are far from ‘well-off.’ For the low-income elderly, Mexico is an attractive destination for retirement due to economic reason. At the national level, still a large number of elderly population is living below the poverty line. In 1999, 9.9% of the 65-and over population and 12.4% of the total population were under poverty level (US Census Bureau, 2004). More than a fourth of all elderly Americans have incomes that place them below 150% of the poverty threshold (US Census Bureau, 2001; Callahan, 1999). Retirement in Mexico could be a viable option for these low-income retirees.

Were Medicare available to retirees in Mexico, additional retirees who are near poor might consider retiring there – e.g., Social Security checks would stretch far better there; and home equity from the US would, converted to cash, go a long way toward home purchase or rental in many areas in Mexico. Warner and Jahnke (2001) examined several options, such as, use of Medicare Medical Savings Accounts for retirees in Mexico, possibilities of modifying Medicare coverage for long term care services received in Mexico, and approaches to improve private health insurance for the elderly, free trade movement of physicians, training and certification of allied health
professionals in the two countries, cross-border collaboration in medical practice (Warner, 1997). Building “health communities” with American-style hospitals and staffed with U.S trained physicians is proposed as another solution to the health care dilemma (McGraw, 1995). Findings of this current study demonstrate that these options need to be considered very seriously by the policy makers.

We have good reason to doubt the glowing report of our one case report. We all can imagine that satisfaction for service does equal high quality. The Mexican physicians according to one respondent do not do normal testing before prescribing medicines, and merely make assumptions about diagnosis without careful evaluation. More research into the quality of medical care both primary care and specialty care would give us more insights into how the medical care situation might be improved for retirees.

More research is needed with bigger and representative sample in order to develop policies and programs for the US seniors in Mexico. The retirement trend to Latin American countries would continue and increase sharply as the baby boomers are approaching retirement age. The gerontologists, sociologists, and policy makers will increasingly face the challenge to address the issues, specifically health issues posed by these migrant retirees both in the source and host nations.
APPENDIX A

QUESTIONNAIRE

CASE STUDY GUIDELINES
UNIVERSITY OF NORTH TEXAS

Study on Health Care Issues of US Retires in Mexico

Questionnaire

Sponsored by University of North Texas

Conducted by: Iftekhar Amin
Supervised by: Stan Ingman, Ph.D.
Professor, Department of Applied Gerontology
Director, Center for Public Service

This questionnaire is a part of a study on “Health Care Issues of US Retirees in Mexico”. The purpose of research is to explore the health care issues that the American retirees in Mexico face. We highly appreciate your participation in this study and we hope that you will find this questionnaire interesting to complete. Your response is always very important and confidential. We will strictly maintain the privacy of your information.

Your participation is voluntary. Please remember that you can skip any question you prefer not to answer. You can stop the interview at any stage and return the questionnaire. If you have any questions about the questionnaire or the study, please feel free to email us at amini@pacs.unt.edu or call us at xxx-xxx-xxxx

THANK YOU!
Part A: Retirement Destination Questions

1. How long have you lived in Mexico? _____

2. Where do you live currently? (City, state/province): __________________

3. Where did you live before moving to Mexico (City, State/province, Country?)

__________________________________________________________________

4. What motivated you to retire in Mexico?
   Living cost   Culture   Medical Expenses   Climate
   other, Specify_______

5. A. At this point, how long are you planning to stay here?
   Temporary (may move to somewhere else); if so, please answer B and C
   Permanent (might spend rest of the life)
   Undecided

   B. Where are you planning to move from here?
   (City, State/province, country) _____________________________

   C. Why are you planning to move out of your current location?
   _______________________________________________________

6. A. Do you live alone?     Yes      No

   B. If “no,” who else lives with you?     Spouse only      Spouse and
   children
   Children only
   Other (specify)____________

7. What kind of establishment do you live in?
   Multi family home   Single family home   Apartment
   Nursing home    Assisted living facility
Other, Specify___________________

8. A. How would you evaluate your decision to retire in Mexico?
   I made a right decision (If you check this box, please go to B)
   I do not know yet
   It was a wrong decision (If you check this box, please go to C)

B. Would you please list 3 best reasons why you think retiring in Mexico was a right decision?
   i)_______________________________________
   ii) _________________________________________
   iii) ________________________________________

C. Would you please list 3 best reasons why you think retiring in Mexico was a wrong decision?
   i)_______________________________________
   ii) _________________________________________
   iii) ________________________________________

Part B: Health Care Utilization

9. How would you describe your health condition?
   Poor    Good    Excellent

10. A. How many days of the last 12 months have you been sick?

B. What kind of sickness? ________________________________

11. How often do you visit the doctor? ________________

12. A. Were you hospitalized in the last 12 months?   Yes      No
B. If yes for what problem(s)? __________________________

C. How long have you stayed in the hospital? ___________________

13. A. Do you have any chronic conditions?  Yes  No
(Note: A chronic condition is continuous or persistent over an extended period of time. Chronic diseases include heart disease, cancer, stroke, chronic liver disease and cirrhosis, diabetes, Alzheimer, etc)

   B. If you have answered “yes” to the previous question, please list what chronic condition you have?__________

14. Do you have any physical disability?
   Yes, disability with special equipment needed
   Yes, disability with no special equipment needed
   No physical disability

15. How would you evaluate your emotional health?
    Poor    Good    Excellent

16.  A. Are you eligible for Medicare in the US?    Yes      No

   B. If yes, do you have Medicare Part B?    Yes      No

17.  A. Are you continuing the premium for Medicare Part B?    Yes      No

   B. If “No”, why you did not continue Medicare Part B?
    _______________________________________________

18. How do you cover your medical expenses?
    Medicare   IMSS   Private Insurance   Out of Pocket (no insurance)

19. Were your hospital expenses covered by your insurance?    Yes      No

20. What proportion of the cost is covered by your insurance? _________

21. Does your insurance cover long term care?    Yes      No
(Note: Long term care means medical, social, and personal care services, such as nursing home care, home and community based care, hospice care, or respite care, required over a long period of time by a person with a chronic illness or disability)

22. A. Does your insurance cover medication?  
   Yes  No

B. What proportion of Medicare cost is covered by your insurance?  
__________________

23. A. How would you evaluate the reimbursement process?  
   Poor  Good  Excellent

   B. If your answer is “Poor,” why do you feel so?  ________________

24. A. How would you evaluate health care options available for you in Mexico?  
   Poor  Good  Excellent

   B. If your answer is “Poor,” why do you feel so?  ________________

25. A. How would you evaluate the insurance policy obtaining process?  
   Poor  Good  Excellent

   Not applicable

   B. If your answer is “Poor,” why do you feel so?  ________________

26. Was the information easily available?  
   Yes  No

27. Do you make trips to US for medical care?  
   Yes  No

28. If yes for what kind(s) of care?

29. What are major obstacles you face here in terms of health care? List them according to their importance.
   a. __________________ __________________________
### Part C: Demographic and Socio Economic Data

<table>
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<tr>
<th>Question</th>
<th>Options</th>
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<tr>
<td>30. Age</td>
<td>Less than 65</td>
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<tr>
<td>31. Gender</td>
<td>Male</td>
</tr>
<tr>
<td>32. Marital status</td>
<td>Married</td>
</tr>
<tr>
<td>33. Number of Children</td>
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</tr>
<tr>
<td>34. Race</td>
<td>Non-Hispanic White</td>
</tr>
<tr>
<td>35. Yearly income in dollars</td>
<td>Less than $15,000</td>
</tr>
<tr>
<td>36. What is/are your source(s) of income currently?</td>
<td>Salary/wage</td>
</tr>
<tr>
<td>37. Previous occupation</td>
<td></td>
</tr>
<tr>
<td>38. Current occupation (if any)</td>
<td></td>
</tr>
</tbody>
</table>
39. Years of education:  0-8 years   9-12 years  13-16  16 and above

THANK YOU FOR TAKING THE TIME TO ANSWER THIS QUESTION!
CASE STUDY QUESTIONS

1. Tell me the happiest day in your life—this question establishes rapport.

2. Talk about your parent’s retirement the decision.

2. Some people go to Florida to retire, think back on the decision to come to Mexico, tell me what was going on in your mind?

2a. Tell me what was going on in your spouse’s mind.

2b. Talk about your family’s thoughts when you decided to retire to Mexico.

3. For a moment think about, when you made up your mind to come to Mexico, what did you think would be the most difficult part of retiring in Mexico?

4. For a moment, think about, what you thought would be the best Part of retiring in Mexico.

5. In thinking about when you made the decision to retire in Mexico, talk about the other places that were considered and the reasons you decided against them.

Being retired

The next questions discuss being retired.

1. Think for a moment that you lived in the United States, talk about what you think your life would be like.

2. Suppose you were giving advice to someone about retiring to Mexico, What advice would you give?

3. What is a typical day like for you, being retired in Mexico?

4. Talk about the advantages and disadvantages of being retired in Mexico.
**Health care**

1. Talk about your health care in Mexico
3. Describe what a typical doctor’s appointment is like.
4. If you had to change any part of the health care system, talk about those changes
5. Talk about reasons you may see a physician.
6. Talk about the problems you face here (if any) when you need health services. Do you think these can be improved? How? And why not if the answer is “no”?
7. Most US seniors occasionally make trips to US talk about your trips to US, too? Describe how often and the reasons you make trips to US?
8. What are your concerns about health care for the retired US seniors in Mexico? Do you think these can be improved? How? And why not if the answer is “no”?

**Insurance and payment questions**

1. If you had to make changes to Medicare part b? Talk about the changes you would make.
2. Do you participate in IMSS (the governmental program)? If yes, discuss the procedures.
3. Discuss your thoughts about buying international insurance?
4. What advice would you give to a person about insurance payment who is retired in Mexico?
5. Talk about your overall thoughts about the health care payment in Mexico.

**General social questions**

1. Talk about your life here,
2. Most people retire for a better quality of life, what things would you change here.

3. Talk about your future plans.

   15a discuss thoughts about moving to a different place/country at a later time? Why and why not?

Demographics

1. Currently do you work? If yes, what type of job? Would you mind telling us what is your current source of income? Which of the following range is correct about your current annual income?

2. What is your age? Are you married? Please tell us about your educational background.

3. How long have you lived in Mexico retired?

4. Where did you live before moving to Mexico (city, state/province, country)?

5. Before we finish, is there anything else you would like to tell us about?
APPENDIX B

CASE STUDIES

(To maintain confidentiality, pseudonyms have been used)
Dr. Williams is a 73 year old retired dentist. He moved to Lake Chapala in 1997 with his German wife. He works part time at a full service dental clinic that provides all kinds of dental services from surgery to crowning, except orthodontics. He is happy with his additional income of around $250 a week.

A TV show on travel channel motivated him to explore Mexico as a retirement destination. He considered California, Florida, Arkansas or Texas for retiring. But none of these places fits his criteria. Two factors played a role in his decision making: affordability and climate. California would be expensive for him. Moreover, the climate is not good enough. Florida is hot and humid. On the contrary, Mexico is very affordable and the climate is very nice. He regrets for not moving here earlier. It is all about making up one’s mind and acting accordingly. He knows many people who talk about moving, but they don’t act on that and stay in their homes and end up in nursing homes.

He and his wife then sold everything they had in the States and bought a house here. Settling down here was hassle-free for him as he bought a furnished home with a car, and also hired the same maid that worked for the previous owner. There is a big American community in Jalisco. Canadians probably outnumber the Americans and Germans. There are also a number of French, Polish and Hungarians living there.

I have a Chinese fellow in my community, a guy from Poland, the next door neighbor is Hungarian…… two Mexican dentists and two Mexican nurses. So it’s almost like the United Nations here.

For him life is very convenient here. Things from all over the world are available there to purchase. If he wants to go for shopping to big cities he has to go to Guadalajara International Airport which is very close to where he lives. Cost of living
here is very low. He gets fresh foods all year round. He needs only a few Spanish words
to survive and he never had any trouble because of language. In addition, he feels safe
here. He knows he lives pretty close to his family and can drive back there anytime. He
repetitively appreciated the climate in Mexico.

Dr. Williams’ typical day starts at about 7:30 am. He wakes up and has a nice
breakfast with his wife. He then leaves for the clinic around 10 and works there until 2
pm. In the afternoon they get into the pool, and have light dinner in the evening. Before
going to bed, they watch TV for a while. They can watch all American TV programs
there. He makes trips to the US only for business purposes. If he wants to see his
family he usually invites them to Chapala. His children come to spend their vacations
with him. He thinks he is living a better life there and he would live longer because of
reduced stress and a slower pace of life. He has also made some good friends.

Most of our friends are Mexicans. We gonna live in Mexico we need Mexican
friends. If you have a Mexican friend, it usually means somebody you can call 2
am in the morning and say I need help. And they will be here. I do not think I
would do that in the States.

Because of his background as a health care provider, Dr. Williams loves to talk
about the health industry there. He feels that the quality of health services he receives
here is far superior to that in the United States. Like most Americans he had the
perception that the US health care system is number one in the world, but once he
came here it was perhaps the biggest shock for him to see that he was wrong. For
example, in his clinic he has a digital x-ray machine with color imaging from Germany.
There are several big hospitals in Guadalajara with up-to-date equipment. The doctors
are also very thorough here doing medical tests and exams. To his surprise he learned
that most of the medicines he used to take in the United States are actually made in Mexico.

Not only are the medications much cheaper in Mexico (may be a third or fourth of a price), but he can get most of them without a prescription. When he goes to a doctor, he does not necessarily need an appointment.

Dr. Williams speaks very high of the health care system in Mexico. Here all the medical students have to work for the IMSS national health insurance for two years after their graduation and the salary goes to the school. After the two years of service they receive their diplomas. This requirement applies to other professionals such as lawyers and accountants, too. He thinks this is a very good system.

His biggest worry about the health care in the US is the rationed care that gets stricter with age in terms of eligibility. He does not participate in Medicare Part B because it seems costly to him. Medicare is not free, and there is a deductible for taking the services. So going to US for services does not seem logical to him. He is also against buying any international insurance for the same reason. The international insurance has a deductible and many hospitals and doctors do not accept it. With the IMSS, he had never a problem seeing a specialist. His wife recently saw a specialist and did not encounter any problem with accessing the specialist.

He believes that the Guadalajara Medical School has a very good program to train the health care professionals, and it is perhaps the largest international medical school in the world. According to his estimate, there might be two or three thousand American students getting training in this school. His personal experience with the doctors in Mexico is all positive. He very strongly recommends other retirees to buy
IMSS for their health care coverage. The IMSS covers everything including doctor’s fees, X-rays and so on. For minor health problems he usually goes to a private doctor who charges him $10-$20.

When asked about moving again in future, Dr. Williams questioned back, “Why would I? We got a beautiful home….. beautiful view, climate. I am not going anywhere.”
CASE STUDY II

Mr. Paterson works part time for a public policy consultant business in US. He describes himself as semi-retired. Most of his works are done through computer from Mexico. He thinks that computer has made a lot of difference in his life. He has Masters Degree in Public Policy from Louis and Clark, Portland, Oregon. He is 59 and married. His household income is between sixty to eighty thousands a year.

Before moving to Mexico 5 years ago, he and his wife had been spending their extended vacations in Mexico for about 10 years. From their experience travelling through Latin America during their vacations, they chose Mexico for retirement destination. He said that they are enjoying better weather and also happy to experience a different culture while living in Mexico. On top of that, the living cost there perhaps is lower than any other part of Latin America. It was not only his decision, but his wife also wanted to move to Mexico.

When he told his other family members about the decision to move to Mexico, they had a mixed reaction. Although they do not have any kid, both he and his wife have aging family members in US. So, they go back and forth quite a bit to meet with the family. This is one of the difficulties he faces for being further from the family. He has seen many people, who have grand kids, move back to US at some point. As a result, there is a lot of buying and selling of “gringo” (US expatriates) properties goes on in Jalisco all year round.

When they decided to move, their biggest concern was finding a good neighborhood where they would feel comfortable to live. It turned out that there are a number of places more every year where new subdivisions are being established for US
expatriates. In some coastal areas there are expensive subdivisions where the “gringos” live. He has seen a lots of communities around that are friendly towards the gringos including one in which he currently lives in Lake Chapala.

Mr. Paterson had always an interest in different cultures. While he was in school and college he travelled to Chile a couple of times. His interest in exploring other cultures and experiencing them played a role in his frequent and extensive international travels. He was always curious to experience things outside the borders. He in fact considered Chile first as his retirement destination. His wife and he both liked the central valley of Chile. In his opinion this is probably the most wonderful place in the world. But it is many more air miles away. It takes 12 hours to fly there from United States. So he had to rule that out from his retirement destination list. It did not seem practical to retire in Chile whereas to retire in Mexico is much more practical. Mexico is within the driving distance from the States. He often drives back to Guadalajara from the States.

He thinks that for middle class Americans, it is a place where one can get a lot more for one’s money. It’s a more social and relaxed environment and he gets a lot of stimulation because besides Mexicans there is a wide variety of people that he comes in contact with. In Ajijik, and Chapala there are people from all over the world. Recently he went to San Miguel Ajiande and was surprised to see it’s huge international community. He meets a lot of interesting people, and visits interesting places. “For an older person it’s a pretty exciting place and environment to live in.”

Due to his job, Mr. Paterson has to travel back and forth which is expensive for him. However, it is not a big deal. He knows many other seniors who do the same back
and forth traveling. But still living in Mexico is worth it because it has a slower pace of life and more scope to socialize.

Although he feels people are friendly there, he has seen many American seniors who come back to US because they don’t fit there. They feel isolated there because they don’t integrate or live in not so friendly communities. He thinks that picking a community that fits one’s lifestyle is the most crucial factor in living in Mexico. Some US seniors have a lot of Mexican friends, while some do not have any. Mr. Paterson has many Mexican friends. He spends a lot of time in socializing, helping people, and networking. He is a member at the Lake Chapala Society. It has a giant library, classes, all kinds of activities, lots of things to do.

He feels safe in Mexico, but he admits that he has to be careful about being at some of the places, such as the border towns. He thinks that the border towns are dangerous, and also not environment friendly. Although he feels he is generally safer there compared to any big US city, he always keeps this in mind that he is a foreigner there. He is just a visitor there.

There are more advantages in living in Mexico than disadvantages. For him, technology has made everything lot easier. In the urban cities in Mexico all the services one would expect are available. There are internet and cell phones and all kinds of stuffs that he can keep contact with anybody anyplace he wants. There are fewer and fewer disadvantages. The legal system is different than that of the US. He believes that one has to realize that it is a different legal system and different way of life for people if he/she is interested to live there.
Mr. Paterson and his wife both perceive themselves as pretty healthy. Although they don’t have many health problems, they feel themselves lucky as they can buy drugs at a much cheaper rate there.

Also, the private doctors are pretty good there and not much expensive. The cost of visiting a doctor is a fraction of what it costs in US. He believes that one can get as good care in Guadalajara as anywhere in the world. Now the flip side of that is that he has to be always being careful in picking a doctor. Since the medical profession is not regulated in Mexico like in US, and also due to corruption, it is much easier for people to get a license there. So, carefully picking a good doctor through checking references is the precondition of getting good health care there. For Americans getting good care is easier compared to the Mexicans. “There have been newspaper stories that Americans are getting better treatment in IMSS than Mexicans. I think that may be hard to prove. But I would not be surprised if it’s true.” According to him, this is perhaps due to the perception of the Mexican interns about the north Americans. Perhaps they perceive the Americans as having higher status and therefore treats them differently.

He visits doctors for his knee problem and some arthritis. He is happy that he gets care for very low cost in Mexico. He also seeks alternatives health care for these problems. He has the option to choose a naturopath or an acupuncturist or any other kind of alternate healer. He has seen people with cancer to go to Mexico when they are in their last stage and try experimental treatments with alternative health care.

In his opinion, in many ways the Mexican health care system is ahead of that of US. They have a system for everybody. Problem is they don’t have enough money; there are too many demands, corruption, and governmental bureaucracy and so on.
However, he thinks that they still deserve credit for having a healthcare system where everyone has some access to it.

According to Mr. Paterson observations, most people make trip to US at least once a year for healthcare purposes. Although some have private American insurances, there is limited coverage in Mexico through these insurances. So, people have to make trip to US. However, this situation is changing. The private insurance companies are now-a-days changing policies and offering American standard insurance in Mexico.

Mr. Paterson is a big supporter of universal healthcare. He thinks that US is more focused in cure than prevention. The US health system needs to change so that people who are not well to-do or upper middle class gets healthcare access. “We have a sickness system. We wait until people gets sick, and then to cure them.” In his opinion, Mexico and Europe are doing a better job in terms of providing healthcare to general people.

Mr. Paterson is not Medicare eligible yet. So he is in providence system. His deductible is fairly high. For his healthcare he mostly pays out-of pocket. He does not participate in IMSS because he has American insurance and travels back and forth. Moreover, if he has an emergency in Mexico his insurance company would reimburse him. He is aware that IMSS is a good alternative; it does not cost more than $300 to $400. Most of the people he talks to who have it are reasonably satisfied with IMSS.

Although he is happy with the culture and climate there, he has some concerns regarding the future of Mexico. He is worried that the way Mexicans are treating their environment would create a lot more problems in future. For example, the Lake Chapala is polluted with heavy metals and the fish of that lake is not safe to eat. On top of that,
the population increase and corruption are some of the other problems that concern him greatly. In future he might move to Chile. “Like I said before I would seriously look at Chile if I didn’t have any contacts left in US. My mother is elderly. But at some point, I will look at Chile as one place. I think it’s just wonderful. It’s little more European and little more expensive than Mexico.”
Dr. JOHNSON is a 73 year old retired cardiologist. He moved to Mexico from Texas in 1998. Dr. Johnson attended the University of Edinburgh, and did his residency in occupational medicine. He retired early because the threat of malpractice suits increased and the practicing medicine was no longer what it was in the golden days. He could afford to retire in any place in the US, but he thought he would definitely have a good quality of life in Mexico. Several factors pushed him to retire in this foreign country. He said he was fearful of the immigration reform, and had the fear of terrorist attack in the US. Besides, his wife could not tolerate the heat and humidity of the Texas Gulf coast. “She is an outdoor person in terms of gardening; she could not do that anymore in Texas.”

He provides informal consultation on medical issues free of charge for charitable purposes. He cannot charge, because he does not have a Mexican license of Mexico. He did not want to go through the troubles of getting one. If people want to pay something he would take a donation for one of his charity projects. He makes pretty good money from his investments in the United States. He is quite well off. He and his wife get almost $2000 a month from their Social Security. That’s enough to live on a monthly basis in Mexico. Plus they have their retirement trust. If they need to draw more money they can use their savings. His annual income is a little over $100,000 a year.

Dr. JOHNSON said that the US seniors there come with a different range of income. He thinks that their income ranges form low to high, for instance many people who have retired from California of course were able to sell their house at much higher
prices than here and were able to buy a very nice piece of property for probably a third of what they paid in California. Most of them are very successful people, writers, people from entertainment industry, and heads of corporations. So they had pretty good incomes. There are ex-pilots, lawyers, accountants, doctors, dentists. There also some people who have small incomes, and retired on Social Security. They do a lot of charity work and while they don’t donate money, they donate time. Most of these people come here since the cost of everything has gone up pretty significantly in the US. In his words, in some neighborhoods there is “a lot of noise, lots of festivals, lots of going up and down the streets…. advertizing. It’s noisy. Lots of dogs burking in the night,” In contrast, in his neighborhood the scenario is different. “Most of the really wealthy people live in our subdivision which is nicer and quieter. The homes are better taken care off. They retain their value.”

The economic situation was another reason for the move. He thinks he got an improved quality of life here in Mexico. He was able to retire early since he moved to Mexico, and now is enjoying life free of stress and worries, and anxiety of practicing medicine.

My life here has been very good. I could not believe I slept 8 hrs for the first time in 25 years (after moving to Mexico). My stress levels are lower, blood pressure is lower. Other than back problem I do quite well. I believe I am still alive because of the quality of life and the less of stress, worries.

He is involved with a lot of charitable works and various ethnic clubs such as the garden club, orchid club, music appreciation society, writing club, and Lake Chapala expatriates society. During his free time, he reads a lot, listens to music, and does charitable work.
I am busy. Retirement is not sitting in the house and listening to music. You can be involved or can not be involved. It can be private. But the quality of life is good.

His moving to Mexico was very stressful. The economy was down and selling the house was not easy for him. He had to move his furniture to Mexico. He felt that integrating with the Mexican culture is essential for him to live here. Perhaps his Mexican background helped him to integrate into Mexican culture better. He also speaks Spanish fluently. He visits different parts of Mexico, studies the culture and customs, and associates with the locals. He comes to Texas two or three times a year to see children, meet old friends, and to do some checkups. During his visits in the US, he does his blood work, chest x-ray, cardiogram and all other check ups he thinks are necessary.

He pointed to many of the problems with IMSS. He thinks that the cost of having IMSS is reasonable, but the drawback is long waiting time and also one has to go through the local clinics. These local clinics work as gatekeepers and refer the patients to specialists if necessary. According to his experience getting into hospital is difficult. Those hospitals use old medicine, and do not have any private rooms. What Dr. Johnson finds disturbing is that they try to treat many diseases without proper diagnosis. For example, they would treat coli even without doing the stool culture or blood work. In his opinion, the general practitioners in Mexico lack knowledge and experience, and are misinformed, but the specialists in Guadalajara are excellent. He sees doctors primarily for acute problems. He had a kidney stone, gallbladder stone, and some other similar problems. He had a car accident once. If there is anything that is significant he tends to return to the US. If there is any emergency, he goes to
Guadalajara. For example, if he needed a heart catheterization, he would definitely return back to the United States. He does not have IMSS or any international health care insurance. He only has Medicare Supplemental. Sometimes he pays out of pocket but the cost is far less than in the US. One can get a hip replacement for $10,000 in Mexico vs. $50-70,000 in US.

Dr. Johnson believes that if IMSS wants to deliver improved quality of care, it should charge more. Now it costs only about $300 a year per person to get IMSS coverage. The other option to deal with healthcare issues of US seniors is to change Medicare. He once tried through a congressman to pass a bill to allow the large expatriate group to use Medicare here in Mexico. There are enough doctors and nurses retired here who could be on the governing board to maintain quality. He believes that it could really benefit US seniors to have care there through Medicare. It could be cheaper, too. He would allow Medicare to be used anywhere in the world for emergencies.

From his experience as a healthcare provider he knows that many of the people who are retired here are going to have more medical problems such as heart disease, high blood pressure, diabetes, strokes, fractures, surgeries. It should be only fair if Medicare provided them service regardless of where they live since those people have paid or are paying for it. Medicare might not reimburse for elective surgeries but it should reimburse for at least the emergency type care.

Dr. Johnson said that some of his friends pay private physicians out of pocket while having IMSS as a backup for hospital care. There are people who come down here from the US for instance for dental work. Dental work is reasonably priced here
about one-third the cost in the US. Few years back he had a kidney stone and the total
cost of being in the hospital three days, antibiotics and medication, and the surgery fell
in the range of $3500. Whereas in the US, that would cost him $30,000-$50,000
probably.

He repeatedly mentioned that he feels he enjoys a good life in Mexico. The
Music Appreciation Society organizes quality concerts worth international musicians,
and the Lake Chapala Society offers classes in Spanish, cultural classes, anthropology
classes, history classes. The Lake Chapala Society helps the expatriates with
insurance, and burial cost. There are lots of activities; one could be doing something
everyday.

The expatriate community here does a tremendous amount of charity. You could
be busy everyday doing something, party or cocktail party, charitable events,
auction or dance or dinner to raise money for charity. I belong to a cooking club.
We have cooking competition once a month.

His future plan is to continue doing just what he is doing: enjoying life, enjoying
music, doing a lot of reading which includes not only political reading, but also historical
reading and learning more about plants and flowers. He will try to keep up with his
medical literature and continue doing some charity work. He might swap houses with
someone from another country, go there for a month. Go to some country to live there
two or three months just to learn about the culture, the people and the language. He
would love to go to Europe, but there are many problems there now. First, the cost of
living is very high in Europe now a days. Besides, there are so may Muslims there who
are taking over Europe, specially Spain, France, Germany, Holland, and England. He is
not very comfortable with the growing number of Muslims in Europe as Muslims are not
 awn, assimilating. He does not want to put himself in jeopardy going to Europe. On the contrary, Latin American countries seem more stable and safer to him.

The problems such as high crime rate and the deteriorating environment in Mexico concern him heavily. He thinks the water in Guadalajara is polluted. The Lake Chapala fish are very contaminated. In addition, he has to remain self vigilant because of the drug related crimes and all other types of crimes around.

You have to be careful because there is carjacking, personal assault, and robberies and there have been murders. So you always have to be concerned about your personal security all the time. Reporting a robbery or assault is very difficult in Mexico. There is a lot of bureaucracy and I think the fingerprint system is just poor. Police are corrupt. Then there are the drug cartels that have practically taken over Mexico. You have to be vigilant.
REFERENCES


AHEC. (2005). Facts submitted by Michael Denis, Director, Prairie Area Health Education Center, UNT.


