



Original article

Parents' Traditional Cultural Values and Mexican-Origin Young Adults' Routine Health and Dental Care



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A B S T R A C T

Purpose: To investigate the prospective associations between Mexican-origin mothers' and fathers' traditional cultural values and young adults' health and dental care utilization and to test the moderating role of youth gender.

Methods: Mexican-origin parents and youth ($N = 246$ families) participated in home interviews and provided self-reports of parents' cultural values (time 1) and young adults' health status and routine health and dental care (time 2; 5 years later). Logistic regressions tested parents' traditional cultural values as predictors of routine health and dental care, accounting for parent nativity, parent acculturation, family socioeconomic status, youth gender, youth age, and youth physical health status. We also tested whether youth gender moderated the associations between parents' cultural values and young adults' routine care.

Results: Young adults whose mothers endorsed strong familism values when they were in mid-to-late adolescence were more likely to report at least one routine physician visit in the past year as young adults (odds ratio [OR] = 3.47, 95% confidence interval [CI]: 1.23–9.83, $p = .019$). Furthermore, for females only, mothers' more traditional gender role attitudes predicted reduced odds of receiving routine health (OR = .22; 95% CI: .08–.64, $p = .005$) and dental care (OR = .26; 95% CI: .09–.75, $p < .012$) in young adulthood.

Conclusions: Our findings highlight the importance of examining intragroup variability in culturally specific mechanisms to identify targets for addressing ethnic/racial disparities in health care utilization among Mexican-origin young adults, during a period of increased risk for health-compromising behaviors and reduced access to care.

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IMPLICATIONS AND
CONTRIBUTION

Findings documented benefits of Mexican-origin mothers' familism for young adults' routine care but potential barriers of mothers' traditional gender role attitudes for daughters' care. Fathers' values, in contrast, were unrelated to young adults' care. Identifying culturally specific factors that explain Mexican-origin young adults' routine care is important in reducing/eliminating health disparities.

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Increasing youth's access to and use of preventative health care are key objectives of Healthy People 2020 [1]. Annual routine visits to health professionals provide opportunities to screen for preventable health problems, monitor chronic illnesses, and provide health information [2,3]. In adolescence

and young adulthood, routine care is critical because youth engage in a range of health-compromising behaviors and are at increased risk for mental health difficulties, which can have long-term implications for their health [4]. Young adults also face greater barriers to health care access and are less likely to use preventative care than adolescents [4,5]. These trends underscore the importance of identifying factors that promote routine care during the transition to young adulthood [5].

Ethnic/racial group membership is a key determinant of health care access and use in the US [6,7], and Latinos are less likely than other ethnic/racial minority individuals to visit a physician and dentist annually and/or have health insurance [6,8–10]. Despite decades of national attention [11], ethnic/racial disparities in health care access and use persist [6,12]. Even with the implementation of the *Patient Protection and Affordable Care Act of 2010*, Latinos remain less likely to have health insurance and access to quality care than whites and blacks [12]. Because Latinos are the largest US ethnic/racial minority group and projected to reach 119 million by 2060 [13], these disparities have significant economic and public health implications [14].

The underrepresentation of Latinos in health research [15], coupled with limitations of research on ethnic/racial disparities, contribute to the persistence of these health inequities. One limitation arises from the treatment of Latinos as a monolithic group, despite the heterogeneity within this population [3,16,17]. A second limitation pertains to lack of attention to how specific cultural values explain variability within ethnic/racial groups in their health care [11]. Most research focuses on differences between broadly defined ethnic/racial groups' access to and use of routine care [6–8,10]. The implicit assumption is that members of an ethnic/racial group are homogenous, such as in their cultural values and, consequently, few studies examine whether cultural factors explain intragroup variability in health care. Addressing this gap, we tested whether Mexican-origin mothers' and fathers' traditional cultural values when their offspring were adolescents predicted daughters' and sons' routine care during the transition to adulthood. A focus on Mexican-origin individuals is warranted because they experience poorer access to and less frequently use routine care than Latinos from all other national origin subgroups [2,3,16], and they comprise 63.9% of US Latinos [13].

Parents' Traditional Cultural Values

Cultural frameworks in the field of health [11] and cultural ecological models in human development [18] guided our focus on parents' cultural values as mechanisms that may foster (or inhibit) young adults' routine care and as sources of within culture variability [12,18]. Research on Mexican American families informed our attention on two values: familism and traditional gender role attitudes [15,19]. Familism values are defined by an emphasis on the needs of the family over those of the individual members, family as providers of support, and the importance of fulfilling family obligations [20–22]. Theoretically, familism values are considered a cultural asset that enhances supports and resources within the family, and in turn, promotes family members' health and well-being [15,20,23]. To date, the links between familism and physical health have been studied primarily in relation to Latino adults' chronic disease management [15]. Familism, operationalized as values regarding cohesion and organization [24] or supportive

behaviors [25], was associated with better disease management. In contrast, familism values emphasizing obligations had negative implications for Latino adults' (particularly females') chronic disease treatment [15]. In theorizing about the role of parents' familism in young adults' routine care, we anticipated that stronger familism values would be beneficial for young adults because parents may be more likely to provide support for and prioritize the needs of their children's health care over their own. Along these lines, Latino, black, and white mothers' prenatal familism values were positively associated with infant birthweight and negatively related to asthma severity at age 3 [23]. We extended this work to test whether mothers' and fathers' familism values when their offspring were adolescents predicted the increased likelihood of young adults' routine health and dental care five years later.

A second key Mexican cultural value is traditional gender role attitudes [19], which emphasize that childrearing and domestic activities should be designated to females, and economic provision and authority/decision-making should be males' responsibilities [26,27]. Prior research focuses on linkages between Latino youth's/adults' gender-typed qualities and their health-compromising behaviors [28,29], but we do not know whether parents' gender role attitudes have implications for offspring's routine care. We predicted that parents' more traditional gender attitudes, because they reflect greater paternal authority within the family and stronger maternal caregiving of offspring, may enhance parental influence on their offspring's health and, thus, promote young adults' routine care.

Traditional cultural values also have been implicated in Latino parents' differential socialization of sons versus daughters [30,31]. Boys are granted greater freedom to spend time with peers and romantic partners, and girls face more demands to provide family assistance and spend time at home, emphasizing their traditional roles [30,31]. Thus, we explored whether parents' cultural values interacted with youth gender, anticipating that when parents hold more traditional attitudes, there would be stronger positive associations with males' than females' routine care, given the high prestige of males' roles and other-oriented focus of females' [26].

This study also considered the role of mothers' and fathers' values in the context of two-parent families, the primary family configuration for US Latino youth (66.8%; [13]). Although fathers are often overlooked in research on Latino youth, there is a growing body of evidence suggesting that mothers' and fathers' values and socialization contribute in unique ways to youth adjustment [32]. To our knowledge, this study is the first to examine whether fathers' traditional cultural values are related to young adults' health care outcomes.

Study Overview

To advance understanding of ethnic/racial health disparities [6–8,11], this study examined Mexican-origin parents' cultural values as predictors of young adults' routine health and dental care. Mothers' and fathers' values were assessed within a single model to evaluate their relative contributions, and we tested whether associations differed for young men versus women. We used a prospective longitudinal design and accounted for factors that are linked to health care access/use: parent nativity and acculturation [2,16]; family socioeconomic status (SES) [3,10]; and youth age, gender [10], insurance status [16], and physical health status [3].

Table 1
Summary of study measures^a

Measure	Time	Report	Item	Item or sample item (if more than one item)	Response options/coding	Cronbach's alpha
Health use outcomes						
Routine physical care ^b [34]	2	Youth	1	"In the last 12 months, have you had a routine physical examination?"	1 = yes; 0 = no	Not applicable
Routine dental care ^b [34]	2	Youth	1	"In the last 12 months, have you had a dental examination by a dentist or hygienist?"	1 = yes; 0 = no	Not applicable
Parents' cultural values						
Familism values [21]	2	Mothers Fathers	16	"Parents should be willing to make great sacrifices to make sure their children have a better life."	1 = strongly disagree to 5 = Strongly agree	.80 (mothers) .85 (fathers)
Traditional gender role attitudes [26,27]	2	Mothers Fathers	10	"Men should make the really important decisions in the family."	1 = strongly disagree to 5 = strongly agree	.89 (mothers) .86 (fathers)
Covariates						
Youth gender	1	Youth	1	"Are you male or female?"	1 = female; 0 = male	Not applicable
Youth age	1	Youth	1	"What is your date of birth?"	Age was calculated using date of birth and interview date.	Not applicable
Parent nativity	1	Mothers Fathers	1 1	"In what country were you born?"	1 = at least one US-born parent; 0 = both Mexico-born parents	Not applicable
Family SES	1	Mothers Fathers	3	Mothers' and fathers' highest education level (1–11 for grade level; 12 = high school graduate; 14 = associate's degree; 16 = bachelor's degree; 18 = master's degree; 21 = J.D., M.D., or Ph.D.) and annual household income (in dollars).	Income was transformed to correct for skewness, and items were standardized and averaged.	.78
Parents' Anglo orientation ^c [35]	1	Mothers Fathers	13	"I think in English."	1 = not at all to 5 = extremely often or always	.90 (mothers) .91 (fathers)
Physical health status ^d [34]	2	Youth	1	"Think about the last 12 months. In general, would you say your health is:	(1) poor, (2) somewhat good, (3) good, (4) very good, or (5) excellent	Not applicable
Current health insurance [34]	2	Youth	1	"Do you currently have health insurance?"	1 = yes; 0 = no	Not applicable

^a Measures were forwarded translated to Spanish and back translated to English by separate individuals. A third Mexican-origin speaker reviewed final translations [36].

^b A "yes" response indicates at least one routine care visit in the prior 12 months. For those who reported a routine physical and/or dental examination, a follow-up question asked "Where did you have this examination?" Response options were "private office," "community/school/work health clinic," "hospital," or "other."

^c Mothers' and fathers' Anglo orientations were averaged.

^d Because very few young adults reported "poor" health, we combined "poor" and "somewhat good" to indicate "suboptimal" health [6].

Methods

Participants

Data came from 246 Mexican-origin youth and their parents recruited from schools in a southwestern metropolitan area [33]. To be eligible, families included two adolescents, a biological mother and a biological or adoptive father (of at least 10 years) living in the home, mothers of Mexican descent (93% of fathers also were), and fathers' employed for 20 hours/week or more. This study focused on the older siblings (50% female; 53.7% US-born), referred to hereafter as target youth/young adults, who were 15.49 years old (standard deviation [SD] = 1.57) at time 1 (T1; 2002–2003) and 20.65 years old (SD = 1.57) at time 2 (T2; five years later; 2007–2008). All youth at T1 and 66.4% at T2 were living with parents.

At T1, mothers and fathers averaged 39 years (SD = 4.63) and 41 years of age (SD = 5.77), respectively and had an average of 10 years of education (M = 10.33, SD = 3.73 for mothers; M = 9.87, SD = 4.37 for fathers). Annual median family income was \$40,000. Most parents (70%) had been born outside the US; this subset had lived in the US for an average of 12.37 (SD = 8.86) and 15.17 (SD = 8.77) years for mothers and fathers, respectively. Interviews were conducted in Spanish

(67% of parents; 17.5% of youth) or English (33% of parents; 82.5% of youth).

T2 interviews were conducted with over 75% (n = 185) of the families who participated at T1. Nonparticipants at T2 (n = 61), compared with participants, reported significantly lower T1 incomes (M = \$37,632, SD = \$28,606 for nonparticipants; M = \$59,517, SD = \$48,395 for participants) and lower maternal education (M = 9.48 years, SD = 3.45 for nonparticipants, M = 10.62, SD = 3.80 for participants). Thus, a composite of income and parents' education was created to measure family SES, and was included as a control.

Procedures

Data were collected via home interviews at T1 and T2. After obtaining informed consent/assent, interviews were conducted separately with youth and parents by bilingual interviewers. Families received honorariums of \$100 (T1) and \$125 (T2). The University's Institutional Review Board approved all procedures.

Measures

All measures are shown in Table 1.

Table 2Frequency of routine care in the past year, health status, and access to health services at T2 (N = 152)^a

	Females, %	Males, %	Total, %
Routine physical exam (prior 12 months)	50.0	30.4	40.3
Routine dental exam (prior 12 months)	57.1	31.9	44.6
Current health insurance	58.0	49.3	53.6
Facility for routine physical care			
Private office	80.0	52.4	69.6
Community/school health clinic	14.3	47.6	26.8
Hospital/emergency room/urgent care	5.7	0.0	3.6
None of the above	0.0	0.0	0.0
Facility for routine dental care			
Private office	87.5	86.4	87.1
Community/school health clinic	7.5	9.1	8.1
Hospital	5.0	0.0	3.2
None of the above	0.0	4.5	1.6
Self-report overall physical health status ^b			
Excellent	13.9	12.3	13.2
Very good	20.3	34.3	27.0
Good	39.2	42.5	40.8
Somewhat good or poor	26.6	11.0	19.1

^a The current sample includes participants with data at T2 on health variables, a subset of the larger sample.^b For comparisons between males and females, we categorized youth as “suboptimal,” (i.e., somewhat good or poor) versus “optimal” (i.e., good, very good, or excellent) health because very few participants selected the response “poor” [6].

Results

Descriptive data on health care access and use are shown in Table 2. Less than half of the sample reported routine health (40.3%) and dental care (44.6%) at least once in the prior 12 months and slightly over half of young adults had health insurance (53.6%). Chi-squared analyses revealed that females reported more routine physical, $\chi^2(1) = 5.53, p < .05$ and dental care, $\chi^2(1) = 8.97, p < .01$, than males, but no differences were found in current health insurance, $\chi^2(1) = 1.05$, not significant. Most young adults received their routine physical

(69.6%) and dental care (87.1%) in private doctors'/dentists' offices. Furthermore, females were more likely than males to receive routine physical care in a private office, $\chi^2(1) = 9.86, p < .05$, but no gender differences emerged in where dental care was received. For physical health, females (26.6%) were significantly more likely than males (11%) to report “suboptimal” (poor or somewhat good) physical health, $\chi^2(1) = 6.00, p < .05$.

Next, we conducted logistic regressions in MPlus 7.4 testing mothers' and fathers' familism values and gender role attitudes (T1) as predictors of young adults' routine physical and dental care (T2), controlling for parent nativity and Anglo orientation, family SES, and young adults' age, gender, physical health, and current insurance status. Full information maximum likelihood robust was used to account for missing data [37]. To examine youth gender as a moderator of associations between parents' values and young adults' routine care, we added interaction terms to each model after centering variables. Only significant interactions were retained in the final models. Correlations between study variables are shown in Table 3.

For routine physical care (Table 4, model A), three covariates were significant: females were more likely to have received routine physical care in the past year than males; young adults with insurance were more likely to have had care than those without; and each one-unit increase in physical health was associated ($p = .058$) with greater odds of routine health care. Furthermore, a one-unit increase in mothers' familism values predicted over a threefold increase in young adults' odds of routine physical care. In addition, the interaction between mothers' gender role attitudes and youth gender was significant. In the follow-up model for females, a one-unit increase in mothers' traditional gender role attitudes was associated with a 78% reduction in the likelihood of a routine health visit, odds ratio [OR] = .22, 95% CI: .08–.64, $p = .005$. In addition, health insurance was related to a fivefold increase in a routine health visit for females, OR = 5.70, 95% CI: 1.68–19.35, $p = .005$, and

Table 3

Means and standard deviations and bivariate correlations between study variables

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Young adult age (T1)	—												
2. Young adult gender (T1)	.04	—											
3. Parents' nativity (T1)	.13 [†]	.02	—										
4. Family SES (T1)	.04	.02	.52 [*]	—									
5. Parents' Anglo orientation (T1)	.06	-.00	.79 [*]	.67 [*]	—								
6. Young adult insurance status (T2)	-.10 [†]	.09	.29 [*]	.37 [*]	.33 [*]	—							
7. Young adult physical health (T2)	-.14 [†]	-.16 [*]	.15 [†]	.18 [*]	.20 [*]	.16 [*]	—						
8. Mothers' familism (T1)	-.04	.02	-.17 [*]	-.24 [*]	-.19 [*]	-.25 [*]	-.03	—					
9. Fathers' familism (T1)	.05	-.05	-.33 [*]	-.36 [*]	-.33 [*]	-.25 [*]	-.17 [*]	.21 [*]	—				
10. Mothers' TGRA (T1)	-.00	.02	-.42 [*]	-.45 [*]	-.47 [*]	-.28 [*]	-.16 [*]	.34 [*]	.23 [*]	—			
11. Fathers' TGRA (T1)	-.03	-.07	-.38 [*]	-.49 [*]	-.48 [*]	-.19 [*]	.05	.23 [*]	.25 [*]	.32 [*]	—		
12. Young adult physical care (T2)	-.13 [†]	.25 [*]	.12	.20 [*]	.14	.27 [*]	.10	-.07	-.06	-.19 [*]	-.15 [†]	—	
13. Young adult dental care (T2)	-.14 [†]	.20 [*]	.00	.04	.01	.19 [*]	.20 [*]	.11	-.10	-.12	.00	.27 [*]	—
Means and standard deviations													
Total sample M	15.48	—	—	-.01	2.95	—	3.29	4.43	4.46	2.03	2.06	—	—
SD	1.57	—	—	.83	.86	—	.99	.39	.42	.66	.57	—	—
Young women M	15.55	—	—	.01	2.94	—	3.12	4.44	4.44	2.05	2.02	—	—
SD	1.70	—	—	.84	.84	—	1.06	.37	.42	.64	.53	—	—
Young men M	15.41	—	—	-.03	2.95	—	3.44	4.24	4.48	2.01	2.10	—	—
SD	1.43	—	—	.82	.88	—	.90	.41	.42	.68	.60	—	—

^{*} $p < .05$; [†] $p < .10$; [‡] $p = .05$.

Insurance status coded as: 1 = yes, 0 = no; M = mean; SD = standard deviation; N = 246 families; SES = socioeconomic status; TGRA = traditional gender role attitudes; T1 = time 1; T2 = time 2; gender coded as: 1 = female, 0 = male; parents' nativity coded as: 1 = at least one US-born parent, 0 = both Mexico-born.

Table 4

Results of logistic regression: parents' traditional cultural values (T1) predicting Mexican-origin young adults' routine physical and dental care at T2

	Routine physical care T2; model A					Routine dental care T2; model B				
	LO	SE	p value	OR	95% CI	LO	SE	p value	OR	95% CI
Covariates										
Young adult age (T1)	−.06	.14	.664	.94	.72–1.24	−.16	.12	.188	.85	.67–1.08
Young adult gender (T1)	.88	.42	.038	2.40	1.05–5.50	1.07	.40	.007	2.93	1.34–6.41
Parents' nativity (T1)	−.39	.75	.605	.68	.16–2.95	.21	.61	.731	1.23	.37–4.07
Family SES (T1)	−.08	.32	.808	.93	.50–1.73	.36	.36	.324	1.43	.70–2.93
Parents' Anglo orientation (T1)	−.24	.45	.590	.79	.33–1.88	−.28	.45	.533	.76	.32–1.82
Young adult insurance status (T2)	.98	.49	.047	2.67	1.02–7.01	.84	.41	.042	2.31	1.03–5.20
Young adult physical health (T2)	.43	.23	.058	1.54	.99–2.41	.19	.21	.371	1.21	.80–1.84
Traditional cultural values										
Mothers' familism (T1)	1.25	.53	.019	3.47	1.23–9.83	.08	.51	.877	1.08	.40–2.96
Fathers' familism (T1)	−.51	.51	.319	.60	.22–1.64	.43	.60	.470	1.54	.48–4.98
Mothers' TGRA (T1)	.51	.53	.342	1.66	.58–4.70	.19	.49	.697	1.21	.47–3.13
Fathers' TGRA (T1)	−.01	.42	.985	.99	.43–2.27	−.30	.42	.473	.74	.33–1.68
Significant interaction terms										
Mothers' TGRA × young adult gender	−1.99	.65	.002	.14	.04–.49	−1.02	.59	.087	.36	.11–1.16
R ²	.30	.09	.001			.23	.08	.003		

Bolded coefficients indicate significant predictors ($p < .05$); italicized coefficients indicate trend predictors ($p < .10$).

N = 246 families; T1 = time 1; T2 = time 2; gender coded as: 1 = female, 0 = male; parents' nativity coded as: 1 = at least one US-born parent, 0 = both Mexico born; insurance status coded as: 1 = yes, 0 = no; LO = log odds coefficient; OR = odds ratio; SE = standard error; CI = confidence interval; SES = socioeconomic status; TGRA = traditional gender role attitudes.

this was significantly different than the odds ratio for males' health insurance predicting routine health care, OR = .69, 95% CI: .20–2.41, $p = .56$. In the follow-up model for males, mothers' gender role attitudes did not predict routine health care, OR = 1.78 (.52–6.07), $p = .36$, but a one-unit increase in physical health was associated with a twofold increase in the odds of a routine care visit, OR = 2.13 (1.01–4.51), $p = .048$. Although physical health status did not predict females' routine care, OR = 1.50, 95% CI: .86–2.63, $p = .152$, these odds ratios did not differ significantly by gender.

For routine dental care (Table 4, model B), significant predictors were youth gender and current health insurance. The interaction between mothers' gender role attitudes and gender reached trend level ($p = .087$). Follow-ups showed that mothers' more traditional attitudes were associated with a 74% reduction in the likelihood of young women's, OR = .26 (.09–.75), $p = .012$, but not young men's routine dental care, OR = 2.13 (.77–7.33), $p = .13$. Additional analyses examined whether young adults' residence with parents at T2 [1 = living with one or both parents; 0 = not living with either parent] was a significant predictor of care. Coresidence was not a significant predictor, and all other findings remained the same. Because 11 females were pregnant at T2, we also reran the analyses predicting routine physical care controlling for pregnancy; pregnancy was only marginally significant, and all findings remained the same.

Discussion

This study advanced understanding of ethnic/racial health disparities by documenting the role of parents' traditional cultural values in young adults' routine health and dental care among Mexican-origin young adults, the largest national origin subgroup of Latinos [13] and the most disadvantaged in their access to and use of routine care [2,3,16]. Our findings are novel in highlighting the significance of mothers' familism values and traditional gender role attitudes in predicting the likelihood of Mexican-origin young adults' routine care.

Consistent with evidence that young adulthood is a developmental period characterized by substantial barriers to health care and risk for underutilization of routine care [4,5], just over half of the sample reported having health insurance, and less than half of these Mexican-origin young adults reported a routine physical and dental care visit in the prior 12 months. Routine health care visits and medical insurance coverage in this study occurred at rates that were lower than estimates for Latino young adults (18–24 years of age) nationally (59.1% had a nonemergency doctor's office visit in past year; 46% had no health insurance in the past year), consistent with evidence of the disadvantaged status of the Mexican-origin subgroup relative to all other Latino subgroups in their health care access and use [2,3,16]. Routine dental care, in contrast, occurred at similar rates in this sample as among Latino young adults nationally (43.2%; 39). Furthermore, most young adults' care was delivered in private doctors'/dentists' offices; having a usual source of care is one indicator of better quality health care [16].

Females were more likely to report "suboptimal health," but they also were more likely to have had routine health and dental care and to receive this care in a private doctor's office as compared with males [5]. Despite that males and females were equally likely to report having health insurance, insured females were 5.7 times more likely to have a routine physical care visit, but insurance status was unrelated to males' routine physical care. Such findings are important in showing that access to health care (via insurance) increased females' odds of routine physical care, but for males, having health insurance did not translate into better odds of care. Furthermore, a one-unit positive difference in males' physical health status was associated with twofold higher odds of routine care, suggesting that healthier males were more likely, and unhealthier males less likely, to seek routine care. Together with national concerns about the well-being of young men of color [38], our findings suggest the critical need to develop effective strategies for promoting routine care in Mexican-origin young men.

Grounded in conceptual frameworks that emphasize cultural values as mechanisms that shape health and developmental outcomes [11,18], we documented that a one-unit increase in mothers' familism values predicted over a threefold increase in the odds of young adults' routine physical care: When Mexican-origin mothers endorsed strong familism values during their offspring's adolescence, their offspring were more likely to engage in routine physical care five years later, in young adulthood. Building on prior work [23], mothers with strong familism values may prioritize the health and welfare of their family members above their own. Furthermore, their role as a provider of care and emotional support to their family [19] may include ensuring that their young adults engage in positive health care practices, such as annual routine care. Finally, as familism values also underscore the importance of family members as role models [19], mothers with strong familism values may be more likely to view themselves as models for their offspring and demonstrate better routine health practices, which in turn, may promote similar behaviors in their young adult offspring.

Mothers' traditional gender role attitudes were associated with a 78% reduction in the likelihood of routine physical care and a marginally significant reduction in the odds of dental care (74%), but only for females. Instead of parents' traditional gender role attitudes being advantageous for males' routine care (our prediction), we found that mothers' traditional attitudes were disadvantageous for females' care: When mothers endorse beliefs that delegate lower status domestic roles to females [21,26,27], they also may place less emphasis on their daughters' health care needs. This may mean that mothers prioritize the preventative care of husbands and sons over those of daughters or that daughters emulate their mothers' other-oriented caregiving roles, minimizing the importance of health practices that emphasize their personal needs and, instead, focusing on those of others. Addressing the importance of young women's preventative care for their long-term health may be beneficial during preventative care visits.

Fathers endorsed moderately high familism values and gender role attitudes, similar to mothers, but fathers' values were unrelated to young adults' routine care. Because traditional cultural values in Mexican American families encourage fathers to embrace their roles as authority figures and economic providers to their families [21,26,27], fathers' values may be more closely linked to young adults' access to care (e.g., employment opportunities that provide insurance), whereas mothers' caregiving supports utilization of routine care. It is noteworthy that this is the first study to examine the role of fathers' values in young adults' routine care and to provide a direct comparison of mothers' and fathers' values within the same model. Thus, it will be important to test whether fathers' cultural values play a role in other family constellations (e.g., stepfamilies) or other Latino subgroups in future research.

Our findings provided limited insights about the role of parents' cultural values in young adults' routine dental care. Females were almost three times more likely to visit the dentist than males, but (as noted) females whose mothers had more traditional gender role attitudes were less likely to report routine dental care. The only other factor predictive of young adults' dental care was insurance status. Young adults with current health insurance were two times more likely to have visited the dentist in the past year than those without insurance, suggesting the importance of health insurance in promoting routine dental

care. As this study did not ask specifically about dental insurance but only more broadly about health insurance, it will be important to gather more detailed information in future work. Furthermore, like our findings for routine physical care, these highlight the importance of promoting Mexican-origin young men's use of routine dental care.

This study provided new insights into the role of Mexican-origin parents' traditional cultural values in young adults' routine care using a prospective design, but it also has limitations. First, we focused on Mexican-origin families, and future research on intragroup variability in other ethnic/racial groups is essential. Second, because our sample was drawn from one geographic region, it is not representative of all US Mexican-origin families, and thus, further research is needed on cultural factors in health care use with samples from other US regions. Third, we used young adults' self-reported health and dental care utilization. Corroborating these reports with health records will be important in future work.

In the face of these limitations, our study broke new ground in documenting that Mexican-origin parents' cultural values, particularly mothers' familism when their offspring were adolescents, may be an important cultural mechanism that promotes routine health care in young adulthood. Pediatric wellchecks in adolescence may provide key opportunities to reinforce the importance of familial support and expectations for routine health care before the transition to young adulthood. Pulling Mexican-origin fathers into their children's and adolescents' health care use may be particularly important for sons, who are less likely to engage in routine care even when they have health insurance, and who are at risk for engaging in health-compromising behaviors [4]. More generally, our findings suggest that future efforts to eliminate ethnic/racial health disparities need to be informed by culturally grounded research [11,18] that identifies mechanisms that increase the likelihood of high quality preventive care for disadvantaged groups in the US [2,3,16].

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