Panel II: Macrosocial and Environmental Influences on Minority Health

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Ethnic minority populations show patterns of health, health care use, and mortality that differ from the overall U.S. population. Each of the broad groups of minorities (Asian, Hispanic, Native, and African Americans) has a unique background of sociocultural factors that influence these patterns. Thus, the larger social environment for ethnic populations, including political, environmental, historical, and economic factors, is a major variable in possible health outcomes. The individual portions in this panel report of the conference seek to identify such factors for each ethnic group and to suggest those macrosocial influences that are most important for observed health effects.

Key words: minority, socioeconomic, Asian, Hispanic, African American, Native American, health status environment, ethnic

This article provides a summary of macrosocial and environmental influences on health in ethnic minorities. Macrosocial influences are defined as those sociocultural and environmental factors that might affect health and include socioeconomic status (SES), residential factors, education, cultural variables, institutional and political forces, familial factors, and media influences. What follows is a discussion of macrosocial influences on the health of African Americans, Asian Americans, Hispanic Americans, and Native Americans.

African Americans

Race is an aggregate indicator of distinctive historical and contemporary experiences. Understanding racial disparities in health is contingent on the identification of the specific conditions of life that may affect health status and systematic assessment of their role as determinants of differences between the races in health status. Race is often used as a proxy for the influences of biological, cultural, socioeconomic, and political factors, and exposure to racism. All of these components of race are interrelated and may interact with each other. They exert their effects through more proximal mechanisms.

Biological Factors

The study of racial differences in health has been dominated by a genetic model that views race as primarily reflecting biological homogeneity and Black–White differences in health as being largely genetically determined (Cooper & David, 1986). This model emerged in the late 18th century, long before any precise theory of heredity existed, and it was used throughout the 19th century to obscure the social origins of illness, emphasize Black inferiority, and justify policies of inequality, subjugation, and the exploitation of Blacks (Krieger, 1987). The genetic model of racial differences in health is based on three assumptions that are all scientifically flawed: (a) race is a valid biological category, (b) the genes that determine race are linked to those that determine health, and (c) the health of a population is largely determined by the biological constitution of the population (Krieger & Bassett, 1986).

There is more genetic variation within races than between them, and racial categories tend not to represent biological distinctiveness (Gould, 1977; Lewontin, 1972; Littlefield, Lieberman, & Reynolds, 1982). Racial taxonomies are arbitrary, and race is more of a social category than a biological aspect. Genetics determines one's skin color, but it also determines the color of one's eyes and hair. People focus on skin color differences because race is a key measure of social identity and status as well as a key determinant of group access to desirable resources in society. Although the biological contribution to racial differences in health is likely to be small, genetics should not be completely ruled out without empirical verification.

Cultural Factors

Distinctive cultures also evolve as social groups adapt to their environment. Culture is not static but is constantly
re-created as social groups respond to their historical and contemporary experiences. Whereas many researchers neglect culture, others examine it as a set of autonomous individual characteristics, unrelated to living and working conditions and independent of the broader political and social order. The social and economic structures under which groups live can shape values and behaviors in ways that have health consequences. Although there are important commonalities in the African American experience in the United States, there is nonetheless considerable heterogeneity within the Black population. Green (1978) has identified nine distinctive “cultural–ecological areas” for the Black population that vary in history, economics, and across a wide range of social and environmental factors. There is also considerable ethnic variation within the African American population. For example, the Black population in the United States includes Black immigrants from the Caribbean area and the African mainland.

Sociopolitical Power

Power is a neglected variable in research on racial differences in health status. LaVeist (1992) discussed the link between political empowerment and health status. He reviewed evidence that indicates that the political empowerment of Blacks may lead to more community-level political participation, increases in Black employment, and in the overall quality of life of community residents. All of these improvements in social conditions may lead to improvements in health status. In an analysis of neonatal mortality rates in U.S. central cities, LaVeist (1992) documented a strong negative association between Black political power and postneonatal mortality rates.

Racism

This framework explicitly highlights the experience of racism as an important component of race that can have pervasive effects on health status. Racism can transform social statuses (as was earlier noted for SES), determine the degree of exposure to risk factors and health-enhancing resources, and may directly affect psychological and physiological functioning. Recently, Krieger (1990) found evidence of a positive association between the experience of racial discrimination and high blood pressure among Black women.

Mediating Factors

The model depicts several mediating or intervening factors between the aforementioned macrosocial and biological factors and health outcomes. These mediating factors include health practices, psychosocial stress, environmental stress, psychosocial resources, and medical care. Each of the components of race (i.e., biology, culture, SES, political power, and racism) may affect a given mediating factor. These mediating factors in turn relate to each other in ways that produce both additive and interactive effects.

Health Practices

Health behaviors are primary determinants of the heavy burden of disease in the Black population. The Report of the Secretary’s Task Force on Black and Minority Health identified six causes of death that are responsible for 80% of the 60,000 annual excess deaths in the Black population (U.S. Department of Health and Human Services [USDHHS], 1985).

Cigarette smoking and alcohol abuse are risk factors for five of the six causes of death. Higher rates of smoking and alcohol abuse among Black adults represent a dramatic historic shift in the social distribution of these behaviors. Before the 1950s, rates of smoking and alcohol abuse were higher in Whites than in Blacks (Williams, 1991). Efforts to understand and address the health problems of the Black population must come to grips with the social structures and processes that facilitate the initiation and maintenance of particular health behaviors.

Health behaviors are often viewed as matters of personal choice. Yet, the evidence clearly indicates that the social
distribution of health behavior is dependent on cooperative efforts by the state and powerful economic interests. The very existence of the alcohol and tobacco industries, the price and availability of their products, and profitability are due to specific state action or interaction on their behalf. Tobacco, for example, has the highest dollar yield per acre of any crop grown in the United States, due in large part to a price support program operated by the U.S. Department of Agriculture. The federal government spends four times as much on the administrative expenses of the price support program than it does on the Office of Smoking and Health, the federal agency dedicated to educating the public on the risks of smoking (Marwick, 1984).

There are more retail outlets for alcoholic beverages in Black and poor neighborhoods than in more affluent areas (Rabow & Watts, 1984). This has not occurred by chance. Retail outlets for alcoholic beverages are licensed in every state, and there is a positive association between availability and consumption. The need to use alcohol and tobacco is also rooted in social structure. Social and economic deprivation create adverse working and living conditions from which people attempt to escape. Thus, tobacco and alcohol are mood-altering agents frequently used to provide relief from the personal suffering that is induced by large-scale social structures. Not surprisingly, the sale of alcoholic beverages increases during economic recessions and periods of increasing unemployment (Singer, 1986).

Stress: Psychosocial and Environment

Low SES affects the options that an individual has in terms of the type and location of housing as well as quality of life. Intertwined with low SES is a stressful lifestyle that may include poor nutrition, poor education, poor housing, low-paying jobs, and a lack of health insurance and access to basic health services. A substantial portion of the Black population lives in low-income rural or inner-city environments where they are likely to be exposed to a relatively high number of environmental hazards, including pollution, traffic hazards, substandard and overcrowded housing, and crime. Some populations or groups may be more vulnerable to certain risk factors than others. Cigarette smoking (Cooper & Simmons, 1985) and alcohol use (Lex, 1987), for example, more adversely affect Blacks than Whites. It is likely that Black smokers are more exposed to toxic working and residential environments than their White peers. Interactions between race and risk factors should be routinely assessed.

Psychosocial Resources

Research efforts to characterize fully the risk factors and vulnerabilities of the African American population must be balanced by attempts to identify strengths and health-enhancing resources within the population. An exclusive focus on social pathology provides a distorted characterization of the struggles and strengths of a disadvantaged population. However, the focus on positive resources must guard against presenting overly idyllic pictures. For example, some research-

ers discuss the social networks of Blacks as if they were a simple panacea for a broad range of health issues. Although these networks facilitate survival, they likely provide both stress and support (Belle, 1982).

Medical Care

Racial variation in medical care is one of the sources of the racial disparity in health status. Recent national surveys indicate the persistence of large differences in the quantity and quality of medical care among racial and ethnic groups (Anderson, Giachello, & Aday, 1986; Blendon, Aiken, Freeman, & Corey, 1989). Given that most health insurance is received through employment, employment status is importantly related to the ability to receive health care. A substantial proportion of uninsured persons in the United States is in families with adults who work but who either do not have or are unable to afford insurance premiums. Racial discrimination also affects the receipt of health care. The Council on Ethical and Judicial Affairs (1990) of the American Medical Association recently reviewed the evidence that indicates that there are persistent and pervasive racial differences in the quality of health care in the United States.

Conclusion: The Limits of Health Care Reform

It is frequently assumed that simply improving access to medical care will eliminate racial disparities in health. In reality, medical care makes an important but limited contribution to health. The impact of medical care on health status is small compared with that of nonmedical variables (Williams, 1990). Historically, improvements in the standard of living and the physical environment have been more consequential determinants of health status improvements than personal medical care (McKown, 1979; McKinlay & McKinlay, 1977; Powles, 1973). Currently, it is estimated that medical care accounts for only about 10% of the variation in health status (U.S. Department of Health, Education, and Welfare, 1979).

Equality of access to medical care is nonetheless critical to arresting further declines in the health status of African Americans. Adequate prenatal care, preventive medical care (throughout the life cycle but especially during infancy and childhood), early intervention in the course of a disease, and the medical management of chronic illness are critical health care needs of the Black population. It is also likely that improvements in medical care will have a larger impact on the health status of Blacks than of Whites. For disadvantaged groups faced with multiple assaults on health, medical care may be the only health-protective resource, but for groups in favorable socioeconomic circumstances, medical care may make little additional contribution. This is true of prenatal care (Nersesian, 1988), and other evidence indicates that the medical treatment of hypertension is more effective in Blacks than in Whites (USDHHS, 1985). Similarly, estimates of the reductions in mortality rates possibly due to additional medical care also indicate that the declines will be larger for Blacks than for Whites (Hadley, 1982). Thus, although more health care alone will not solve the health problems for African
Americans, efforts to improve health care delivery in the African American community are likely to have a higher than average payoff.

Asian Americans

Our knowledge of the macrosocial influences that affect Asian American health is of much more recent vintage and is much less developed than that of African Americans and Hispanics. Much of this reflects the small size of the Asian American population as well as the more recent immigration of many Asian groups. It has been noted that the incidence of tuberculosis and hepatitis are much higher for Asian Americans than for Whites. On the other hand, coronary heart disease for Asian Americans is much lower. What are some of the macrosocial influences that account for these and other differences?

Probably one of the most significant macrosocial influences affecting the overall health of Asian Americans is U.S. immigration policy. Before 1965, U.S. immigration policy toward Asians was arguably xenophobic, exclusionistic, and racist. Asian immigration was restricted to a trickle—accounting for about 4–5% of the total legal immigrant stream. Passage of the 1965 Act (Wong & Hirschman, 1983) resulted in over 400,000 Asians coming to the United States during the 1960s, constituting roughly 13% of all legal immigration. With the fall of Saigon in 1975, immigration from Asia intensified as many Southeast Asians sought refuge in the United States. During the 1970s, Asian immigration increased to roughly 1.6 million immigrants, constituting 36% of all immigrants (Wong, 1985; Wong & Hirschman, 1983). During the 1980s, a total of 6 million immigrants and refugees were legally admitted to the United States, nearly half from Asian countries and the bulk of the rest from Latin America. The current wave of immigrants and refugees now arriving in the United States seems far from ebbing, and projections suggest that it may be the largest influx of the 20th century (Wong, 1986).

The changes in U.S. immigration policies have much to do with the changing demographic character of the Asian population in the United States. Whereas the total U.S. population increased by 1–11% in the 1970s and 1980s, the Asian American population more than doubled in size each decade. This is the nation's fastest growing minority population (Barringer, 1991). There are now about 7.3 million Asian Americans living in the United States, constituting about 3% of the population. As a consequence of this tremendous growth, the Asian American population is an overwhelmingly foreign-born population. In 1990, about two thirds of the Chinese and Filipinos and three fourths of the Asian Indians, Koreans, and Southeast Asians were foreign born (U.S. Department of Commerce, 1993). The increase of these newcomers to the United States, especially to the inner-city communities, has exacerbated the problems of poverty and has created new health problems such as the introduction of new diseases, language differences and other communication barriers, and the immigrants' skepticism about and response to Western medicine and health practices.

In 1990, approximately 66% of the Asian population was foreign born (U.S. Department of Commerce, 1993). The Asian immigrants' lack of proficiency with the English language to communicate the name or nature of an illness constitutes a real barrier in service delivery and provider-client communications. Many are forced to rely on the advice and assistance of their kin, many of whom are just as uninformed as the new immigrants about available services, or on the bilingual family members and other untrained interpreters in order to convey their symptoms to the health professional. This situation may lead to confusion, delay in diagnosis, or misdiagnosis on the part of the health provider or it may lead to avoidance of these health providers altogether.

On their arrival to the United States, a significant number of the new Asian immigrants initially reside in areas where there is already a significant concentration of members of their own ethnic group. Although tourists may look on these Chinatowns, Koreatowns, Little Saigons, and Little Manilas as quaint little ethnic communities, they are characterized by substandard housing and physical and social decay and deterioration. Unemployment and underemployment, poverty, and crime are prevalent in the Chinatowns in the United States. San Francisco's Chinatown has the second greatest population density for its size in the country, second only to Harlem; the Chinese have a tuberculosis rate about four times higher than Whites and a suicide rate three times that of the national average (Bourne, 1973; Jacobs, Landau, & Pell, 1971; Liu, 1986; Owain, 1975).

The Chinese American community in Boston had a higher infant mortality rate than other groups (Yu, 1982). The crude death rate of Chinese in New York's Chinatown is higher than both the New York City and U.S. figures combined (Liu, 1986; Owain, 1975). Congested housing conditions force low-wage earners and the elderly poor to live in understandard housing, which is not conducive to good health and poses a greater risk to their health.

An image of Asian Americans is that they are a "model minority," that is, a highly successful minority who have overcome their "ethnic handicap" and are socioeconomically well off. However, a glance at federal statistics shows that although Asians are overrepresented in the professional, manager, and administrator occupational categories, they are also overrepresented in the low-paying, labor-intensive service category.

The fact that Asians have higher average family incomes than Whites may suggest socioeconomic parity, but such a conclusion is premature. Because Asian families are more likely to have more wage earners than White families, the additional wage earners may account for the seemingly socioeconomic parity. Furthermore, Asians are more likely to be in poverty and receive less income in return for their educational achievements than are Whites.

The low SES of the new Asian immigrants means that they are unable to afford proper medical care. Moreover, working in the ethnic economy, it is unlikely that they will have any medical insurance. Most of the small businesses in such communities are not required to provide medical insurance for their employees. The Asian immigrants are further handicapped by not being familiar with medical insurance or, ironically, not believing in insuring one's health. Preventive
medical care is not a priority for Asian immigrants. The high cost of medical treatment as well as Asians’ perception of Western medicine may encourage them to seek alternative forms of treatment.

Culture may be instrumental in explaining the differences in the prevalence of certain diseases or illness between the Asian and the White population. The distinctive beliefs, values, and behaviors of Asians that are different from the mainstream culture may produce a different definition of and response to a particular mental or physical condition.

The discrepancy between health statistics and reality can, in part, be attributed to the Confucian teaching in Asian culture, which demands the upholding of a scrupulous public facade at all times—of keeping face, of keeping up appearances—the cultural proscription against public admission of emotional problems. The attitude toward suicide relates closely to the importance of saving face. To forfeit one’s life voluntarily in order to prove the depth of one’s regret is considered a noble death and an honorable solution to problems. In the West, suicide tends to be recognized as a manifestation of mental illness.

The reluctance of many Asian Americans to use mental health services may be related to cultural values regarding avoidance of shame and importance of family integrity. Seeking help would be evidence of personal weakness and “bad blood” and would bring disgrace on both seekers and their families. Moreover, many Asian Americans believe that the avoidance of morbide thoughts is a way of gaining mental health (Lorenzo & Adler, 1984; Root, 1985; Sue & Morishima, 1982). Because Western mental health practices often stress introspection and disclosure of morbid thoughts, Asian Americans frequently tend to avoid Western forms of psychological treatment and prefer medical treatment for emotional problems.

Although some Asian American subgroups, such as the Chinese, feel embarrassed about expressing feelings of loneliness and sadness, they find it easy to somatize. Emotional problems may be converted to somatic complaints, particularly of the respiratory and gastrointestinal variety. Psychosomatic complaints may have their basis in Asian thought. Somatization to the Asian is an acceptable way of expressing inner conflicts. Though it is embarrassing, and at times taboo, to express feelings or emotions, concern about one’s body and its functions is acceptable (Ryan, 1985).

Lastly, the difference in health service utilization rates between Whites and Asians may be due to the access that Asian individuals may have to alternative resources for dealing with emotional and physical problems that are more consistent with their cultural values than are Western human services. Many Asians believe far more deeply in natural herbal healing than in unknown chemicals or even surgery. Hence, many Asian patients will rely initially on herbalists, acupuncturists, and traditional Asian pharmacies for varying ailments and then seek Western medical help only as a last resort (Crystal, 1989; Deinard & Dunnigan, 1987; Kraut, 1990).

In conclusion, the differences in the physical and mental well-being between Asians and Whites are not simply the manifestation of a mental or physical condition but are shaped by macro-social influences—by institutional and political forces such as changes in our racist immigration policies, nativity or generational status, the degree of facility with the English language, residential concentrations, SES, and culture. All of these factors, separately or in combination with each other, affect the health of Asian Americans and should be taken into consideration in any health recommendation or health care policy.

Hispanic Americans

The past decade has witnessed an increase in the number of funded research projects and scientific publications on Hispanic health. This increased attention by the scientific community and public health agencies is partly a response to the dearth of knowledge on the health of Hispanics and corresponds to the phenomenal growth of the Hispanic population during the past 20 years. This phenomenal growth in the Hispanic population is especially critical to our analysis of the impact of macrostructural factors on Hispanic health; we discuss this briefly below.

The Hispanic American population, according to the 1990 census, stands at 22,354,059, a 53% increase from 1980 and more than double the 1970 count. Half the growth for this population is the result of increases in migration; the other half is explained by fertility, or natural increase (Bureau of the Census, 1991b). The majority, or 63%, of Hispanics self-identify as Mexican Americans; 11% self-identify as Puerto Rican; 5% as Cuban; 14% as Central and South Americans; and 7% as other Hispanic (Bureau of the Census, 1991c).

On average, Hispanics are younger than other American groups, with a median age of 26.3 years, compared with 34.6 years for Whites and 27.7 years for African Americans. Although elderly Hispanics are the fastest growing segment of the elderly population, they remain a small proportion of the total Hispanic population (Bureau of the Census, 1991a). There are other demographic factors that directly or indirectly bear on the overall health of the U.S. Hispanic population. For example, Hispanic families tend to be larger than non-Hispanic families, with a mean of 3.80 versus 3.18 family members, respectively. About 29% of Hispanic families have five or more members, compared with about 13% of non-Hispanic families (Bureau of the Census, 1991b). Many of these families live in very limited space, particularly those with children under age 10. Children in these families tend to get sick more often and for longer periods of time, and both young and old are exposed to many stressors.

Although educational attainment levels have improved somewhat, Hispanics continue to enter school later, leave school earlier, and receive proportionately fewer high school diplomas and college degrees than other Americans—and the gap between Hispanics and non-Hispanics continues to widen. For example, Hispanic adults are almost eight times as likely as non-Hispanics to be illiterate. Using the traditional measures of literacy—completion of more than 5 years of schooling—13% of Hispanics 25 years and older were illiterate, compared with just 2% of non-Hispanics in 1991. Figures were highest for Mexican Americans and lowest for Cubans (Vargas, 1988).
High levels of illiteracy contribute to an overall lack of understanding and knowledge about health practices, treatments, and outcomes (Bastida, 1993).

Hispanic men have the highest labor force participation rate among male population groups: Hispanic women have the lowest among female population groups. As of 1991, 78% of Hispanic men aged 16 and older were either working or seeking work. Although increasing, only about one half of Hispanic women were in the labor force in 1991 (Bureau of Labor Statistics, 1991). It is unclear whether these employment rates accurately represent the work status of Hispanic women. For example, a large number of Hispanic women are engaged in paid housekeeping work and are not always counted in government reports; others, mainly undocumented female workers, work in sweat shops and other marginal manufacturing enterprises where they remain invisible to government officials. The important point for this discussion is that both Hispanic men and women are likely to be employed in relatively low-paying jobs. This results in an interesting paradox in terms of accessibility to health care. On the one hand, because Hispanic families tend to have high labor force participation in general, they do not qualify for state programs of medical assistance (e.g., Medicaid). On the other hand, because their low-wage employment is not likely to offer health insurance, they are far more likely than either Blacks or Whites to be uninsured and thus unable to obtain health care when needed. For many with low wages and with large families, their only source of health care—as it is for the poor in general—is the emergency room.

Hispanics have lower per capita income than either African Americans or Whites. In 1989, per capita income was $14,896 for Whites, $8,747 for African Americans, and $8,390 for Hispanics. Hispanic per capita income was thus 56% that of Whites. Hispanic workers earned significantly less as well. For example, the median annual earnings of working Hispanic women in 1990 were $10,099, compared with $12,436 for non-Hispanic women. Among men, Hispanic workers earned a median of $14,141, compared with $22,207 for non-Hispanic men. Lower per capita income and higher uninsured rates account for large numbers of Hispanic families who have no means for accessing health care.

Finally, one in every four Hispanic families—and almost two in five Hispanic children—is poor. Twenty-five percent of Hispanic families live in poverty, as do 28% of Hispanic individuals. Between 1979 and 1989, more than 1 million Hispanic children were added to the numbers living in poverty, despite the fact that they often lived with both parents and had at least one employed parent. Under these circumstances, it is difficult for families to qualify for medical assistance. Thus, large numbers of Hispanic children, who make up one third of the total U.S. Hispanic population, have no regular access to health care.

How can this demographic synopsis help us to better understand and explain some of the pressing health problems experienced today by the Hispanic population? Two facts seem to be salient. First, it is clear that socioeconomic disparity between Hispanics and other Americans may be a leading contributor to Hispanic health status. Second, a lack of access to regular, high-quality health care is a major problem for Hispanics. Thus, the current crisis in health care has made Hispanics even more vulnerable than other populations.

Unfortunately there are serious limitations in existing data on Hispanic health. Nevertheless, existing data indicate that, compared with other Americans, Hispanics are at increased risk for a variety of diseases. Some of these diseases are relatively related to the low SES of the population such as the higher incidence of tuberculosis, which is four times that of non-Hispanic Whites, and the recent rise in the incidence of measles among Hispanic children. Obesity, a condition that increases the risk of several chronic diseases, is more prevalent among Hispanics (National Center for Health Statistics, 1991), as shown by studies conducted by University of Texas Health Science Center in San Antonio (Hazaud, Haffner, Stern, & Eifler, 1988). Hispanics are disproportionately affected by AIDS, which is often linked to substance abuse. Hispanics have twice the percentage of AIDS cases than would be expected given their percentage of the population and three times the expected percentage of female and pediatric AIDS cases. The link between HIV/AIDS and drug abuse is particularly strong for Hispanics (National Council of La Raza, 1992).

When one examines the leading causes of death for Hispanics compared with the general population, important differences emerge. Although heart disease and cancer were the first and second leading causes of death for both Hispanics and non-Hispanics in 1987, the rates were lower for Hispanics. Yet, unintentional injuries and chronic liver disease ranked higher for Hispanics than for non-Hispanics (U.S. Public Health Service, USDHHS, 1990).

Injuries are the third leading cause of death for Hispanics. Work-related injuries in particular are important to this discussion. Hispanic location within the labor market structure accounts for a large number of injuries. Homicide, AIDS, and perinatal conditions were among the top 10 killers of Hispanics, whereas none of these conditions were among the major killers of non-Hispanic Whites (U.S. Public Health Service, USDHHS, 1990).

Perinatal conditions represent the 10th leading cause of death among the Hispanic population and are apparently related to residential factors. South Texas has one of the largest Hispanic concentrations in the country (78%) and offers a good example of how macrosocial influences have affected the incidence of neural tube defects (NTDs) among the Hispanic population of the area. In April 1991, three women gave birth to anencephalic infants within a 36-hr period at one hospital in Brownsville, Texas. According to the Centers for Disease Control, fewer than two cases per year would have been expected for Cameron County. The rate for this region is four times the national rate. Very little is currently known about the causes of NTDs. The Texas Department of Health has noted that a variety of factors have long been thought to play a role in the etiology of NTDs, major ones being SES, valproic acid, and nutrition. Environmental and occasional factors have not been definitively associated with an increased risk of NTDs. However, there are suggested associations between NTDs and occupational organic solvent exposures such as men who work as house painters (Texas Department of
Health, 1992). Although this is a relatively isolated area, it does point to a variety of macrostructural factors—among which the internal economy and the border region appear prominent—impinging on the incidence rate of NTDs for this area and this population.

The environmental concerns of this specific region are of importance to the Hispanic population in general when one realizes that according to a conservative population estimate, approximately one quarter of the U.S. Hispanic population lives along this 2,000-mile stretch of the southern border. Power and politics play a critical role in residential patterns as well as in environmental concerns over the quality of life of a certain residential area. Many Hispanics remain withdrawn from the political power process and as such have exerted little influence over what happens in their communities.

With respect to environmental exposures, migrant and seasonal farm workers face special risks. Hispanics comprise the majority of the migrant and seasonal farm worker population in the United States. The U.S. Public Health Service and USDHHS (1990) have reported an infant mortality rate for farm workers to be about 25% higher than the national average and a life expectancy of only 49 years. The rate of parasitic infection among some groups of farm workers is reported to be as high as 50 times that of the total population. Farm workers are continually exposed to toxic pesticides. They live near fields that are heavily sprayed, and pesticides are likely to be in the irrigation water that many farm workers must use for bathing and drinking. Toxic exposure starts at a very young age, as children comprise a significant portion of the workforce, and often infants are taken to the fields with their parents (National Council of La Raza, 1992).

Finally, and most important, questions remain that concern access to health care and public and private health insurance coverage. Hispanics are more likely than either Whites or African Americans to have no health insurance coverage. In 1990, over 6.9 million Hispanics (32% of the Hispanic population) were uninsured, compared with 26.9 million Whites (13%) and nearly 6.1 million African Americans (20%). Hispanics are overrepresented among the uninsured; in 1990, they comprised 9% of the U.S. population and over 20% of the uninsured population.

Health insurance coverage is directly related to the socio-demographic factors discussed earlier, mainly a younger age and lower levels of education, which are associated with lower skill and lower wage jobs. It is precisely because Hispanics are likely to participate in the labor force despite their poor status that they and their families so often lack any type of health insurance. Given the larger size of Hispanic families, it often means that families are forced to sacrifice basic needs to afford meager health care. After obtaining a free medical examination at a neighborhood clinic, it is common for patients to be unable to afford the soaring price of a prescription. Having no health insurance—or health insurance that requires extensive cost sharing—makes regular health care unaffordable for the "typical" Hispanic family and makes almost all health care unaffordable for families living in poverty.

Health insurance coverage varies widely among Hispanic subgroups: Puerto Ricans are more likely than other Hispanics to receive Medicaid; Cuban Americans and other Hispanics are more likely to be covered by private insurance; and Mexican Americans and Central and South Americans are more likely to be uninsured.

This discussion has highlighted macrostructural factors such as demographic characteristics, change in the work structure, private and public health insurance coverage, and the powerlessness of our populations in taking necessary action to deal effectively with environmental issues. However, it should be emphasized that in addition to deficiencies in national databases that would allow a more rigorous and encompassing analysis of Hispanic health, there are other serious concerns to which researchers and policy makers should give serious attention. One of the most critical issues concerns the appropriateness of concepts and theories that were developed for use with non-Hispanics being applied indiscriminately to Hispanics. Conceptual meanings should be given equal if not greater attention than to linguistic equivalence, because these may present a more complicated challenge. That is, to achieve linguistic equivalence, one may use translation and back-translation. Yet, there are no such techniques to ensure that theoretical constraints or scientific concepts have cross-cultural equivalency. For example, does the concept of "stress" have the same meaning across Hispanic subgroups or between Hispanics and non-Hispanics?

Language differences present a set of difficulties that go beyond simple translation; in particular, the cultural relevance of the linguistic qualifiers we use in closed-ended questions and that are subsequently manipulated into scales for statistical analysis may be problematic. For example, the most common question still used in health studies, the subjective measure of health status, usually demands a response along the lines of "excellent," "good," "fair," "poor," and "very poor." Do we actually know the cultural guidelines and normative interpretations that lead a Hispanic respondent to choose one and not the other? Once responses are obtained, are they comparable to responses obtained from other populations to justify a rigorous comparative analysis? More important, are there barriers to the publication of results that run counter to well-accepted and established theories and constructs? Are reviewers and editors, who in large part do not conduct minority health research, willing to accept explanations or conceptualizations that differ from those typically seen in the literature? These are some of the conceptual, methodological, and political questions that must be addressed if we are to advance our understanding and ultimately improve Hispanic health.

Native Americans

Interrelated macrosocial, cultural, and environmental factors influence the health status of American Indian and Native Alaskans. Cultural beliefs and practices determine how individuals experience and express various illnesses. Treatment of disease is affected by such social factors as access to health care systems, institutionalized racism, and poverty. Environmental factors such as distance to health care providers,
available technologies, and environmental health hazards affect health care and wellness.

Diversity

American Indians are an extremely diverse and heterogeneous population composed of approximately 500 federally recognized nations, tribes, bands, and Alaskan Native villages. Tribal and regional variation are reflected in health behaviors and in morbidity rates (Bleed, Risser, Sperry, Hellikke, & Helgerson, 1992; Gillum, Gillum, & Smith, 1984; Lanier, Bulke, & Ireland, 1989; Rhoades, 1990; Sievers, 1966, 1968; USDHHS, 1985).

Cross-cutting the cultural variation among American Indians and Alaskan Natives is the bifurcation into rural-reservation and urban populations. Following World War II, in particular, federal policies encouraged the relocation from small-scale indigenous communities to large-scale industrial centers, where the majority of the population now lives (Neils, 1971; Price, 1969; Sorking, 1978; Thornton, Sandefur, & Grasmick, 1982). In contrast to their reservation counterparts, urban American Indians are dispersed throughout the general U.S. population, benefiting neither from their own sovereign political and cultural institutions nor from federal institutions responsible for their health, education, and well-being.

Institutional Factors

Long-standing institutional and political forces have shaped the national health policy toward American Indians. On reservations, the federal government is mandated to provide health care through the Indian Health Service (IHS), a branch of the Public Health Service (Garrett, 1990; U.S. Congress, Office of Technology Assessment, 1986). This responsibility transfers to the State Departments of Public Health for Indians living off reservations for a period of 180 days (Smith, 1987; Stuart & Rathbone-McCuan, 1988). Since 1976, IHS has allocated funds for a limited number of urban ambulatory clinics. These clinics have generally diversified their funding sources and so, unlike reservation clinics, may not serve an exclusively American Indian population. IHS is the major health provider and serves 60% of the American Indian population. Information is not available systematically to assess the utilization patterns of the 40% of American Indians not receiving service from IHS. IHS interprets its mandate as the provision of actual medical care (Debruyne, 1990; John, 1991) and allocates funding according to a formula based on years of productive life lost (Handler, 1991). Although this system of allocation has resulted in dramatically increased life expectancy at birth, it has been criticized for failing to allocate resources for chronically disabled children or adults, for long-term care, or demand for services (General Accounting Office, 1991; John, 1991).

Assimilation through education has been an element of federal-Indian relations by the U.S. Commission on Civil Rights (1981). Removal of Indian children to boarding schools in the first half of this century isolated them from the transmission of their culture’s values and practices, including parenting models. Further affecting families and the transmission of culture was the preference by non-Indian social service religious agencies to place Indian foster children in non-Indian families, a practice partially abated by the Indian Child Welfare Act of 1978.

In terms of civil rights, American Indians are not comparable to any other minority or ethnic group (U.S. Commission on Civil Rights, 1981). Whereas immigrants (whether forced or voluntary) started without resources and struggled to gain equal political, social, and economic status, American Indians started with the resources and their control and access was eroded by imperial, colonial, federal, and state policies. Participation in political processes that mirror the mainstream or other minorities may further erode the special status as sovereign, domestic, independent nations.

Racism

U.S. society exhibits a systematic and racist bias against American Indians. Where it is not overt discrimination, American Indians are reduced to stereotopic caricatures (Kramer, 1991, 1992a; Stedman, 1982). On an institutional level, the federal government banned the practice of Indian religion in the 19th century and did not restore that right until the 1974 Indian Freedom of Religion Act. That legislation protects Indian beliefs but so far has failed to protect certain indigenous religious practices. Given that traditional American Indian health care practices are intimately tied to their systems of religion (Primeaux & Henderson, 1981), failure to protect these health practices influences self-care and the willingness to use formal medical services.

Lack of awareness about American Indians pervades health settings. First, American Indians report that they do not expect to be treated fairly by non-Indian health care and service providers (National Indian Council on Aging, 1982) and prefer treatment by culturally sensitive providers, who are usually also Indian (DeGeyn, 1973; Kramer, 1992b). Second, health care providers may not be knowledgeable about relating to the cultural needs of Indian patients (Rhoades, 1990). Indeed, they may fail to even recognize these patients as American Indians (Frost, Taylor, & Fries, 1992).

Health Beliefs

Indigenous health conceptualizations are one area in which it may be possible to generalize across heterogenous cultures. In general, traditional American Indian health care practices are holistic, do not distinguish separate models for mental and physical illnesses, and promote wellness (Adair & Deuschler, 1970; Garrett, 1990; Joe, Gallerto, & Pipo, 1976; Morse, Young, & Swartz, 1991; Primeaux & Henderson, 1981; Waldrum, 1990). Religion and medicine are philosophically integrated in indigenous theories of disease, illness, etiology, treatment, and prevention.

Aligning conceptual models will result in more successful treatment and more rapid recovery (Lewis, 1975). Researchers are beginning to explore the cultural relevance and utility of *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.,
American Psychiatric Association, 1980) classifications for mental illnesses and of diagnostic tools, such as the Minnesota Multiphasic Personality Inventory and the Center for Epidemiologic Studies—Depression scale (Baron, Manson, Ackerson, & Brenneman, 1990; Manson, Shore, & Bloom, 1985; Pollack & Shore, 1980). Understanding disease etiology from a native point of view predicts the types of health-seeking practices that may be chosen (Joe et al., 1976; Lang, 1989; Weiss, Ulbrecht, Cavanaugh, & Buchanan, 1989).

The role of the American Indian family in providing health care to its members is complex and varies across Indian societies. Generalizations about the American Indian family (John, 1988) tend to obscure variations of family structure, of social organization, and of the affect of social policy on the family. Preferences and willingness to give or receive care from family members varies with culture, even for the care of universally respected elders (Cooley, Ostendorf, & Bickerton, 1979; Shomaker, 1990).

Socioeconomic Factors

American Indians are two to three times as likely to live in poverty as non-Indians, according to the 1980 census. Conditions of poverty have been correlated with the high mortality rates for tuberculosis, with the high morbidity rates for anemia and hepatitis (USDHHS, 1985), with both suicide and homicide rates (Young, 1990), and with obesity, which is a significant risk factor for diabetes. In urban areas, poverty reduces access to health care.

Environmental Factors

On reservations, the high rates of poverty, the lack of economic opportunities, and high morbidity and mortality rates produce stressful environments, which may create different patterns of risk for mental disorders and behaviors (Neligh, 1988). A pattern of continuing personal losses is associated with chronic levels of depression noted in American Indian populations (Manson et al., 1985). Stress may also play a significant role in the expression of diabetes and cardiovascular disease, two prevalent diseases among American Indian populations. Accidents are the second leading cause of deaths for all ages (1968–1988) on reservations, accidents reflect, in part, environmental conditions (USDHHA, Public Health Service, IHS, 1991).

Technological and occupational changes affect societies and the health of individuals. Cancer is seen by many Navajos as a culturally valid outcome for disturbing the sacred nature of the land by strip mining. Therefore, families have not aggressively pursued either treatment, legal options, or voluntary relocation (Dawson, 1992). Other technological changes (e.g., modern diet, machinery) have negatively affected health-promoting behaviors, leading to the dramatic rise of diabetes mellitus in American Indian populations after 1940 (Wiedman, 1987).

Conclusions

American Indians comprise 1% of the total U.S. population (U.S. Department of Commerce, Bureau of the Census, 1992); the majority of individuals are dispersed within urban settings, and reservations are remote and isolated. Research on this population, therefore, is relatively costly in comparison with other minorities. The majority of American Indians living in the United States no longer live on reservations, yet research and national-level data sets focus overwhelmingly on that concentrated population. The bifurcations into urban and rural populations add a significant dimension to the already great heterogeneity.

Research on macrosocial, cultural, and environmental factors and on health behaviors has not been consistently pursued for this population. Much of the research has focused on the Navajo Nation, where tribal and health research interests have favorably intersected for most of this century (Adair & Deuschler, 1970; Kunitz & Levy, 1991; Leighton & Leighton, 1944; Levy, 1983). The literature on sociocultural and environmental influences on health does not reflect the tremendous sociocultural diversity of American Indians. The final macrosocial issue we note is the funding of research and demonstration projects that have (a) favored distribution of resources to a single, albeit the largest, American Indian reservation population and (b) failed to focus attention on the health of urban American Indians and on variations in cultural and social factors on health status.

References


New Editors Appointed, 1997–2002

The Publications and Communications Board of the American Psychological Association announces the appointment of four new editors for 6-year terms beginning in 1997.

As of January 1, 1996, manuscripts should be directed as follows:

- For the Journal of Consulting and Clinical Psychology, submit manuscripts to Philip C. Kendall, PhD, Department of Psychology, Weiss Hall, Temple University, Philadelphia, PA 19122.

- For the Journal of Educational Psychology, submit manuscripts to Michael Pressley, PhD, Department of Educational Psychology and Statistics, State University of New York, Albany, NY 12222.

- For the Interpersonal Relations and Group Processes section of the Journal of Personality and Social Psychology, submit manuscripts to Chester A. Insko, PhD, Incoming Editor JPSP—IRGP, Department of Psychology, CB #3270, Davie Hall, University of North Carolina, Chapel Hill, NC 27599-3270.

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Manuscript submission patterns make the precise date of completion of 1996 volumes uncertain. Current editors Larry E. Beutler, PhD; Joel R. Levin, PhD; and Norman Miller, PhD, respectively, will receive and consider manuscripts until December 31, 1995. Current editor Robert J. Sternberg, PhD, will receive and consider manuscripts until February 28, 1996. Should 1996 volumes be completed before the dates noted, manuscripts will be redirected to the new editors for consideration in 1997 volumes.