

¿De Dónde Eres? Latine Identity and Representation in Health Statistics

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In our title we ask *¿De dónde eres?* (“Where are you from?”), which is a question that is often asked of Latines—and gestures toward the liminal place that we occupy in the United States. Latines are both insiders and outsiders in the national arena, socially and politically leveraged to maintain the Black-White divide via their perceived proximity to Whiteness and distance from Blackness.¹

It is therefore in the interest of leaders and power brokers to maintain hegemonic policies, practices, and perceptions that nebulously define Latines as a transracial monolith to obscure the ethnic group’s textured identities, lived experiences, and placement in varying social hierarchies from the nation’s general consciousness. This, in turn, holds major ramifications for the field of public health. Although the discipline has made strides forward in unpacking racial health disparities in its commitment to health equity—defined as the opportunity to attain the fullest

potential health and well-being²—Latines have largely been left out.

Current empirical and theoretical approaches recapitulate decades of outdated conceptions of how Latine identity should be captured and what social factors influence disparities in our health outcomes. This is a detriment not only to the field but also to population health across the country. Indeed, Latines are the fastest-growing demographic, representing 13% of the population in 2000, accounting for nearly 20% in 2023,³ and projected to grow to 28% by 2060,⁴ with growth principally driven by babies born to US-born parents.⁵ Given our size, Latine health will continue to substantially affect the country’s social and economic stability⁶ today, in 2060, and beyond. As such, it is critical to foster efforts that bolster accurate representative measures, add context to rigorous empirical methods, and apply a praxis suitable to the growing majority-minority.

There are several challenges to studying Latine health, particularly those related to empirical methods and health statistics. This heterogeneous population, composed of people who have or whose ancestors have origins in Latin America and the Caribbean, is largely misrepresented in demographic data and health-related outcomes, a trend that has been described in several empirical investigations.^{5,7-9} Across national data sources, Latines are treated as a transracial monolith despite our position as the only ethnic group recognized in the minimum statistical standards of the US Office of Management and Budget (OMB).¹⁰

This is compounded by a half century of mainstream literature uplifting and recapitulating the epidemiological phenomenon of the “Latino health paradox,” cementing the notion that positive Latine health outcomes continue in the face of extreme social adversity.¹¹ The premise of the Latino health paradox is that despite this ethnic group’s lower socioeconomic status, greater stress exposure, and behavioral risk factors, its members have longer life spans and better health outcomes than the general population.¹² However, recent work reveals evidence to the contrary. Despite US-born and foreign-born Latines’ long life spans, they suffer in disease states longer, with comparable health risks to the Black population.¹³ Empirical and theoretical approaches that support such generalizations mask the disparities experienced by the diverse Latine population and exacerbate the myopic, homogeneous lens applied to Latine health. Furthermore, they compromise our ability to disentangle and accurately represent how aspects of race, identity, culture, history, and policy structure

Latines' lives, behaviors, and resultant health outcomes.

Representation in health research and data-driven evidence is twofold. Accurate representation is the practice of data collection and analysis as well as the application of concepts and theory grounded in the contextual and historical realities of Latines' lived experience. Therefore, to dismantle contemporary practices that sustain monolithic narratives, it is critical to challenge the status quo in mainstream public health research, something that has been done among Latine scholars and allies for decades but has yet to be part of the general public health consciousness. This must change.

Motivated by the scholarship of critical race scholars in public health and legal studies,¹⁴ we begin with a brief overview of British and Iberian colonization and how this informs contemporary processes of racialization and ethnic classification in the United States. We then describe how these processes undergird US statistical policies and practices that buttress misidentification and misrepresentation of Latines in demographic and health data (e.g., existing OMB standards) and how they guide the US decennial census. In addition, we argue that analyses of ethnoracial health outcomes need to catch up to the current US landscape to be inclusive of overlapping identities, whether related to ethnicity, race, nativity, or gender. These identities must be accurately reflected in qualitative and quantitative methods to appropriately capture underexplored disparities in Latine health. We offer novel contributions to the field by bringing a critical historical context and alternative praxis to the forefront of public health consciousness in a push toward Latine health equity and justice.

RACE, ETHNICITY, AND COLONIAL HISTORIES

The US system of racial stratification is built around exclusion from Whiteness and has created a Black–White binary, othering those who fall outside of the dichotomy. This racial duality is rooted in British colonial practices of indigenous extermination, enslavement of African peoples, and subjugation of non-White peoples. These practices were extended during the formation of the modern-day settler–colonial state,¹⁵ which in the US context refers to the system of oppression aimed at the erasure of Native Americans and their contributions to the nation by replacing them with the settler population and its “civilization” of the new world.¹⁶

This has produced a phenotypically informed idea of who is Black, who is White, and who is “other” (those who fall outside of the Black–White binary) while simultaneously supporting a melting pot narrative that divorces ethnic identity from racial grouping.¹⁶ For example, ethnic Whites such as those of Irish, Polish, and Italian heritage went through a process of Americanization in which they were absorbed into the White category and divorced of their ethnic and racial identities.¹⁷ Conversely, enslaved Africans were robbed of their ethnic identities as a result of the transatlantic slave trade, forced assimilation, and their grouping into the Black racial category, which also incorporated anyone with phenotypically Black features.¹⁵ Social control of minoritized and marginalized groups has been sustained through the maintenance of a Black–White binary system, with codified privileges ascribed to dominant groups normalized and made rational.

Iberian colonization in Latin America deviated slightly from English imperialism

in the United States. It relied on colonial practices of Christianization, mass murder, and forced labor executed in tandem with procreation as a tool of genocide, which encouraged the forced racial mixing of European, African, and indigenous peoples. As such, a racially fluid hierarchy known as *Las Castas*¹⁸ was maintained.¹⁷ Under this system, Iberian colonial states adopted a structure that upheld Whiteness/Europeanness at the apex, *mestizo* (mixed indigenous and European ancestries) and *mulato* (mixed African and European ancestries) as a middle status, and Native, African, and *Lobo/Zambos* heritage (mixed indigenous and African ancestries) at the forced bottom.¹⁸ Such hierarchies continue among many Latine communities through the practice of colorism, or social grading on the basis of skin tone.¹⁸

Both colonial systems exercised authority and ascribed privileges by keeping those who did not have the phenotypical features associated with Whiteness under the strictest levers of oppression. The legacies of these colonial states have created varied definitions and understandings of race in the United States and between and among Latin American countries, but ultimately definitions and understandings that remain anti-Black and anti-indigenous. This has created varying conceptions of race among Latines, who might see themselves not completely within one racial category but as a reflection of mixed racial identities, making it difficult to find themselves within the settler–colonial Black–White binary.

RACIALIZATION AND ETHNIC CLASSIFICATIONS OF LATINES

Mainstream ethnoracial health disparities research is primed on the assumption

that race and ethnicity are measuring the same concept. However, race and ethnicity are defined differently and mean different things to different people depending on geographic placement and personal understanding of race. Despite the melting pot narrative that is upheld in the United States, ethnicity cannot be divorced from race or other aspects of individual identity in investigations of differences in health outcomes across or among ethnoracial groups.¹⁹ Individuals are not only categorized into socially constructed racial groups on the basis of phenotype or physical characteristics but are also classified into ethnic groups. Therefore, Latine should be considered a multidimensional category, as it intersects with race through people's individual attributes (e.g., shared geographic origin, heritage, and language) and in relation to their place in social hierarchies (e.g., race, gender identity, sexual orientation, and socioeconomic status).¹⁹

Related to conceptions of race and ethnicity is the process of racialization, which describes the social meaning and privileges assigned to people according to shared characteristics, culture, language, nationality, religion, and class.²⁰ Racialization introduces more nuance to how overlapping identities can (dis)advantage individuals' opportunities for health. Importantly, it ushers the classification of groups as "minorities" through the process of minoritization, which emphasizes the active status of racialization.²⁰

The process of racialization, as opposed to racism, is likely a major factor in minoritized ethnoracial health disparities because racialization encompasses attributional and relational aspects of ethnicity,¹⁹ and how they intersect with race and other overlapping identities. This nuance is arguably overlooked in ethnoracial health

disparities research in that it commonly attributes observed ethnic and racial differences in health to structural and systemic racism rather than racialization. Therefore, when planning empirically rigorous investigations into Latine health disparities, we must simultaneously consider attributional and relational dimensions of ethnicity, the lasting histories of British and Iberian colonial practices, and ongoing US imperialism. Each of these acts on Latine social and structural environments to influence health outcomes and behaviors.¹⁷

ISSUES RELATED TO LATINE MEASUREMENT

The processes by which measures of race and ethnicity are socially constructed, understood, and operationalized are important with respect to methodological accuracy and numerical representation in demographic and health research. Many demographic questions on administrative forms and health surveys follow the OMB's Statistical Policy Directive 15,¹⁰ which maintains current federal demographic standards. Until March 28, 2024,²¹ demographic data were collected via two distinct questions addressing whether one is Hispanic/Latine and which racial group one fits into (White, Black, Asian, American Indian/Alaskan Native, and Native Hawaiian or Pacific Islander).¹⁰ As such, in theory, ethnoracial groupings (e.g., White Latine, Afro-Latine, Asian Latine, indigenous Latine, or multiracial Latine) could be derived and represented in national demographic data.

However, decennial census demographic profiles reinforce a sixth, quasi-racial group status—Latine—wherein the five racial groups and those who fall

outside of these groups (e.g., Hispanic/Latine, two or more races, some other race) are presented alongside one another according to demographic makeup.²² The latter three groups, however, are not part of the current federally recognized racial group options but are included in decennial census race and ethnicity measures. Therefore, despite holding meaningful significance in terms of the numerical representation of marginalized peoples, they are often excluded from demographic profiles, health measures, and general health statistics. All of these factors must be considered when thinking about why 44% of Latines either did not respond to the race question or reported "some other race" on the 2020 US census,²³ as this contributes to continued Latine misrepresentation in demographic and health research.

Inaccuracies in ethnoracial data measures are one reason why the practice of collapsing race and ethnicity into a single ethnoracial question has become more common in health surveys and administrative forms in recent years. Offering one ethnoracial question is a way to increase data completeness. However, data completeness is not the equivalent of data accuracy, nor does it necessarily promote equity in statistical measures. Instead, the practice of collapsing questions aids production of the Latine monolith and serves to mask health disparities.

Public health scholars have also pointed to additional limitations in our current data collection practices for Latine populations. Zambrana et al. conducted an analysis of 101 existing data sets from 1960 to 2019 that included information on demographic, socioeconomic, and health characteristics.²⁴ They found that although some surveys maintained appropriate variables that represented

aspects of Latine multidimensional ethnic identities, by and large data were cross sectional, and significant gaps exist in data concerning children and youths, sexual identity and gender orientation, race and mixed-race measures, and immigration factors including nativity and generational status.²⁴ McSorley et al. showed that Latine populations from the US territory of Puerto Rico are often missing entirely from secondary health data sources maintained by the Centers for Disease Control and Prevention public health monitoring and surveillance systems.²⁵

As argued by Gómez, if Latines are to count, we must be counted.¹ For this to happen, exhaustive race and ethnicity options must be offered when data are collected, and data cleaning practices must have historical and contextual grounding.

A CALL FOR A BETTER ANALYTIC APPROACH

Analyzing and interpreting Latine intersectional ethnoracial identities is critical for the advancement of Latine health equity in the field. Despite current flaws in racial category choices for Latines, existing and potential measures in health surveys show promise in increasing Latine representation. This involves using demographic measures to explore the multidimensionality of ethnic identity and its intersections with factors such as race, age, sexual identity and gender orientation, nativity, and generational status. Simple steps can be taken to do so, including the creation and use of ethnoracial variables in population health research (e.g., White Latine, Afro-Latine, Asian Latine, indigenously Latine, multiracial Latine, other Latine). Alternatively, an anthropological approach in which communities

self-define their Latine identity through qualitative data could be considered.

Data disaggregation practices also provide a pathway to health equity. When within-group differences are assessed, health disparities and needs typically masked by ethnic/racial groupings can be identified and addressed. However, to do so, it is crucial to prioritize a population-specific approach; otherwise, models may become too large and may lose contextual precision. This means that without maintaining a focus on a specific Latine population, health outcomes of interest, and contextual grounding within the US sociostructural landscape, data disaggregation and multidimensional models may, in turn, create a masking effect by creating too many outcomes to sort through. It is indeed a delicate balance, but one that must be achieved to advance Latine health equity and justice.

CONCLUSION

As a field committed to prevention, public health works best when health threats are detected early and intervention strategies can be applied to mitigate the lasting effects of people suffering in disease states longer than they should. Health statistics are leveraged in service of this cause. Therefore, efforts to prevent and eradicate Latine health inequities demand improvements across our data practices, including representation.

Through this editorial, we have sought to advance efforts for Latine representation in health statistics in several ways. We have offered a historical context, often missing in the public health mainstream discussion, that illuminates how modern-day conceptions of race and ethnicity are rooted in colonial legacies. This context is meant to encourage us to move away from

monolithic conceptions of who is Latine to incorporate data collection and analytic approaches that allow us to appropriately identify Latine disease and health risks across intersecting identities. Through more methodological rigor and better practices, we can subvert the questions around where Latines are from and instead show that we are home, we are represented, and our health matters. *AJPH*

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M. L. Mitsdarffer conceived the idea for and developed the foundation of the article. M. L. Mitsdarffer wrote major parts of the article, and A. M. McSorley aided in writing, provided feedback, and helped to get the work to its final stages. E. M. Rojo helped with the literature review. J. G. Pérez-Ramos provided feedback, aided in writing, and provided thought leadership. M. L. Mitsdarffer, A. M. McSorley, and J. G. Pérez-Ramos contributed to the final version of the article and final editing.

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