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# Targeting Hispanic Populations: Future Research and Prevention Strategies

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Minority populations face a wide variety of economic, institutional, and cultural barriers to health care. These barriers and low levels of education and income pose significant challenges for health professionals in developing cancer research and prevention-control strategies. It is suggested that specific segments of Hispanic populations fit the model of an underdeveloped country in the intermediate stage of epidemiological transition. Since noncommunicable diseases have not yet fully emerged in some of these Hispanic population segments, the opportunity exists to apply primordial prevention strategies. Such campaigns would focus on dissuading members of these populations from adopting negative health behaviors while promoting positive lifestyle choices. Optimal programs would increase cancer screening participation and discourage risk behaviors through community-oriented, population-based interventions. Future directions in prevention and control efforts for minority populations should include expanded health insurance coverage, improved access to health care, greater emphasis on minority recruitment in health care fields, focused epidemiologic and clinical research, and identification and replication of effective components within existing prevention-control programs. — *Environ Health Perspect* 103(Suppl 8):287–290 (1995)

Key words: Hispanic, cancer, prevention, research

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## Introduction

Contrary to popular belief, the notion of a great American melting pot is fallacious. Underserved populations present diverse experiences, backgrounds, cultures, values, perspectives, and problems. Within populations lie broad variations in education, socioeconomic, and acculturation levels. The implicit individuality of underserved groups extends to health status and promotion, including cancer issues. Evidence for this assertion appears, among other places, in cancer incidence and mortality statistics: African-American men experience a 25%

higher risk of all cancers than nonblack men; Hispanics have overall lower death rates from cancer than non-Hispanic whites but higher mortality rates in certain forms of the disease; and among southeast Asian American men, the lung cancer rate is 18% higher than that of the white population, while the liver cancer rate is 12 times higher [SM Schwartz and DB Thomas, unpublished data; (1)].

Examination of cancer research and prevention-control strategies requires that we bear in mind the diverse nature of racial and ethnic populations. Certainly, the need exists to explore factors unique to each underserved group. However, to provide greater focus in this report, we will offer examples that pertain to the growing population of Hispanic Americans.

## Barriers to Health Care

Hispanics face significant barriers to seeking and attaining health care, and these barriers often render experiences within the health care system deficient. While particular deficiencies are rooted in an overall lack of cultural awareness throughout the medical community, the larger issue is the socioeconomic disparity that impedes access to health care services for a large segment of the general population.

Hispanics experience a lower rate of health insurance coverage compared to the rest of the country. One-third of the Hispanic population is uninsured, while

only 13% of non-Hispanic whites fall into that category. The uninsured numbers are even greater for individual ethnic groups such as Central and South Americans (40% uninsured) and Mexican Americans (36%) (2). Studies show that compared with privately insured Hispanics, uninsured Hispanics are less likely to: *a*) have a regular source of health care, *b*) have visited a physician in the past year, *c*) have received a routine physical examination, and *d*) rate their health status as excellent or very good (3).

Lack of insurance is a critical factor in Hispanic underuse of health care services but certainly not the only one. Another is the lack of perceived risk of disease. Although this is a tendency within all segments of society, it is more acute in some populations. Hispanics often use emergency rooms for immediate health care needs, primarily because of a tendency to wait until health problems reach a critical stage. This may be the result of ignoring warning signs or not having sufficient knowledge to recognize these signs. Small health problems become large and costly health problems, and one consequence of this is the overloading of public health facilities in urban areas where minority populations are concentrated (4). This overloading results in long lines for patients and extended waiting periods. Compounding the situation, these same emergency rooms often are the sites of routine primary treatment for the economically depressed, many of whom are Hispanic.

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This paper was presented at the President's Cancer Panel Conference on Avoidable Causes of Cancer held 7–8 April 1994 in Bethesda, Maryland. Manuscript received 9 March 1995; manuscript accepted 24 March 1995.

This review was supported primarily by the South Texas Health Research Center, The University of Texas Health Science Center at San Antonio, Houston's A Su Salud grants funded by the National Cancer Institute 1 R01 CA38347 and U01CA52939, and the National Hispanic Leadership Initiative on Cancer: En Acción funded by National Cancer Institute grant U01 CA59379. The authors thank Dani Presswood for his editorial assistance with this paper.

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Abbreviations used: NHLIC, National Hispanic Leadership Initiative on Cancer; and HHANES, Hispanic Health and Nutrition Examination Survey.

Additional institutional and cultural barriers impede the path to health care, and even when minority populations do access medical services, it often is accomplished with much sacrifice. The working poor typically lack flexible hours, adequate transportation, and child care. They encounter long, difficult-to-understand enrollment forms and personnel whose attitudes toward minority patients may be negative. They find staff members and health professionals who typically are neither bilingual nor culturally sensitive, and often the minority representation within the health care provider fields is low (5).

The list of barriers continues. Given the demographic profile of underserved populations with high proportions of members who have not completed high school (6), live below the poverty level (6), and lack health insurance (2,3), combined with the host of existing institutional and cultural barriers, a very negative picture emerges regarding the challenges health care professionals face in developing health promotion and disease prevention programs targeting Hispanics.

These barriers to adequate health care are even more pronounced among those segments of the Hispanic population that fall in the migrant worker and undocumented immigrant categories. Many of these Hispanics are relatively recent immigrants who have been forced to leave their homelands by economic, political, and other circumstances. It is believed that such migration and the subsequent culture shock are stressful experiences that can lead to health-threatening conditions such as anxiety and depression as well as accompanying feelings of irritability, helplessness, and despair (7). Such health stresses may increase the risk for organic disease and somatic and functional illness (8). These problems have traditionally been ignored, but clearly they must be recognized and addressed.

Though this picture may appear bleak, there are bright spots, or positive signs, as well. For example, Hispanics exhibit certain behavioral tendencies that support a health promotion model. Studies show that Hispanics have a lower smoking rate than other segments of the general population, which is primarily a result of lower, although increasing, tobacco consumption among Hispanic women (9–11). Research among Mexican–American women also reported lower rates of alcoholism than among non-Hispanic whites (12). In addition, positive health patterns were found in the typical Hispanic diet: high in fiber; reliance on

vegetable rather than animal proteins; and presence of carbohydrate staples such as corn tortillas and rice. These positive health behaviors should be researched more thoroughly and reinforced.

A South Texas study found that in combination with economic and educational advances and acculturation, Mexican–American women also tended to adopt negative health practices (13). For example, smoking and drinking rates were evidence of trends that more closely approached the higher rates among non-Hispanic white women (13). Adoption of mainstream behaviors appears to increase risks for cancer and other diseases common to the larger society (14). Examination of the South Texas data by age, education, and language use showed that the behaviors associated with time and cost, such as participation in preventive screening services, did not change with acculturation (15).

### Epidemiological Transition and Primordial Prevention

Interestingly, the South Texas study participants possess characteristics that may fit the model of underdeveloped countries entering the middle stage of epidemiological transition (Figure 1) (13,15). The model takes into account various stages that countries pass through as economic development occurs and new patterns of mortality are observed (16). At the earliest point, primary health problems include infectious diseases and infant mortality. After this, accidents and injuries become major contributors to mortality. In the intermediate stage, economic progress typically results in an increase in deaths associated with non-communicable diseases such as those related to tobacco, alcohol, and obesity. In its advanced stage, epidemiological transition reflects a decrease in the incidence of these diseases as the more affluent society adopts healthier lifestyles. Although the United States has reached this later stage, sectors of the population with lower education and income levels commonly exhibit risk

behaviors that more closely resemble the intermediate stage (17).

In the South Texas study, Mexican–American females appeared to increasingly adopt negative health behaviors such as smoking. An increase in economic and educational opportunities for this population may also serve to increase these negative behaviors. Since limiting personal improvement opportunities is not an option, the questions arise: How can this underserved population reach the advanced stages of epidemiological transition without experiencing the higher levels of noncommunicable disease associated with the intermediate stage? Is it possible to adopt the positive health practices that accompany increased affluence while rejecting the negative behaviors?

The answers lie in an approach called primordial prevention, an effort to prevent populations from adopting lifestyles that generate future increases in noncommunicable disease incidence (16,17). Since non-communicable diseases have not yet fully emerged among the Mexican–American population, the opportunity exists to accelerate movement through the intermediate stage of epidemiological transition to a point at which higher socioeconomic status begins to correlate with decreased levels of obesity, smoking, and alcohol abuse (13,17,18). Prevention strategies should be actively applied that would combine education and health promotion campaigns to discourage young women from risk behaviors while encouraging proper nutrition, exercise, and preventive care. Ideal primordial prevention programs would be offered in a culturally appropriate context, with the integrated participation of individuals, institutions, and community organizations (13,18). Since it is more difficult to change addictive behaviors than to prevent them, we should identify those segments of the Hispanic population in which the primordial prevention opportunity can be optimally applied (13).

### A Model for Research and Prevention

An example of such an integrated approach is the National Hispanic Leadership Initiative on Cancer (NHLIC): En Acción, which is coordinated by the South Texas Health Research Center in San Antonio. This is a National Cancer Institute-funded program targeting diverse Hispanic populations in Texas, California, Florida, and New York. The program works with Puerto Ricans in New York City, Cuban Americans in Miami, Central and South

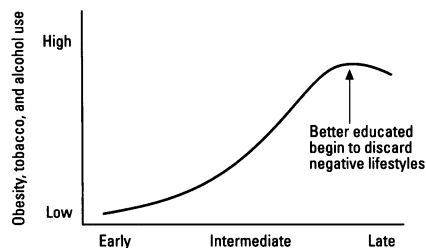


Figure 1. Health risks during epidemiological transition.

Americans in San Francisco, and Mexican Americans in San Diego, San Antonio, and Brownsville, Texas.

The mission of the NHLIC: En Acción is to bring together national and regional experts in medicine and public health with local and grassroots community leaders to engage Hispanic populations in a comprehensive cancer prevention and control effort. It is believed that an increase in cancer screening services and a reduction in cancer risk factors can be achieved among these Hispanic populations through the multicomponent, population-based intervention that this program employs.

Currently there is a lack of timely cancer data on all Hispanic groups. It has been more than a decade since the Hispanic Health and Nutrition Examination Survey (HHANES) was conducted, and that project represented a limited spectrum of Hispanic populations. The NHLIC: En Acción represents one of the first efforts to develop a comprehensive assessment of all cancer risk factors among men and women from the various Hispanic populations. One of the program's initial endeavors has been a baseline telephone survey of more than 9000 Hispanics, which, in combination with data collected from other sources through archival methods, will contribute valuable information to future program planning, policy, and advocacy efforts.

It is hoped that the NHLIC: En Acción not only will have an impact on the lives of many Hispanics, but also will examine the nature of community-based disease prevention and control research and identify ways that health promotion messages should be delivered to culturally diverse communities. This project may stand as a model for future programs, as it has embraced elements that investigators historically have determined to be effective approaches to target research and technology transfer to underserved populations.

### Future Directions

What are some other future directions for cancer prevention and control among minority populations? It is of utmost

importance that all Americans have adequate access to health care. It is a national tragedy that more than 37 million citizens, many of whom are among our minority populations, are listed among the medically indigent. We need to extend health insurance to the working poor and others who cannot afford or do not qualify for subsidized coverage.

As our underserved populations continue to grow, industries are increasingly directing marketing efforts toward this segment of consumer America. One negative consequence of these efforts is that sales and consumption of unhealthy products such as tobacco and alcohol will almost assuredly increase among these populations. Effective programs are needed to counter these marketing campaigns and to provide underserved consumers with the information and skills to protect themselves.

Greater emphasis should be placed on recruiting and training health care providers from various racial and ethnic populations and increasing cultural sensitivity among the current professionals in all health fields. The responsibilities for overcoming pervasive and long-standing barriers to health care must be shared by the medical and research communities as well as by educators and members of the lay community. Only when the educational efforts of health care providers are accomplished can real progress in breaking down these barriers be realized. An example of the present minority underrepresentation in health fields is that although Hispanics comprise more than 9% of the U.S. population, less than 5% of physicians in this country are Hispanic. The proportion of Hispanics in dentistry and nursing is even lower—between 2.5 and 3.5% (19). There is a strong need to provide a more equitable distribution of health professionals in areas that are traditionally underserved such as inner-city and rural sites.

Research priorities that focus attention on health problems and health promotion specific to underserved populations are of paramount importance. As with health care providers, we need to involve more minority

researchers and to improve cross-cultural competence of nonminority scientists in research. Efforts should be made to fill major gaps that exist in the collection, analysis, and dissemination of data related to the health of Hispanics and other ethnic and racial groups. Epidemiologic research can contribute to our knowledge about prevalent cancer problems among these populations and enable us to better understand why incidence rates for other types of cancer are low. More clinical studies will help physicians assess treatment effectiveness and improve quality of care. Also, we need to gain greater insight into the influence of cultural considerations as they pertain to underserved populations participation in cancer control efforts, and the problem of underrepresentation of racial and ethnic populations in clinical trials should be addressed.

Much has been learned about environmental influences in cancer incidence and mortality. We must intensify efforts to bridge the gap between science and the public, to increase awareness and invalidate misconceptions, and to disseminate information about risk factors and the importance of personal behavior in cancer prevention. Efforts should focus on finding optimal approaches in educating the underserved public about positive and negative health behaviors. Greater precision is needed to identify particular segments of underserved populations that are at highest risk for developing cancer and to enable individuals to make informed lifestyle choices.

In developing and executing new cancer prevention and control strategies, we would be wise to learn from past experience. The few underserved population intervention programs offered to date support the need for more community models, and typically involve media and community outreach in reaching target populations. Future endeavors should evaluate the strengths and weaknesses of existing programs, identify those elements that achieve desired results, and replicate strategies proven to be effective and successful.

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