

The Emerging Hispanic Population: a Foundation for Cancer Prevention and Control

Amelie G. Ramirez, Roberto Villarreal,
Lucina Suarez, Estevan T. Flores*

Although making up only 9% of the U.S. population and concentrated in urban areas of a few states, Hispanics are found throughout the country and represent a mix of historical and cultural backgrounds. This diverse group cuts across racial and ethnic lines, with origins in various countries of Europe and North, Central, and South America. The Hispanic population has several distinguishing demographic characteristics, including its rapid growth rate, relative youth, and low educational and socioeconomic levels. However, considerable differences exist among Hispanic groups, particularly in median age, household size, education, and family income. The majority of Hispanics face barriers to health care access, including a lack of health insurance coverage, underrepresentation in health care fields, and cultural and language differences. These distinct demographic characteristics and barriers have a direct impact on the risk of cancer in Hispanics and on the development of prevention and control strategies. The purpose of this review is to examine the demographic and socio-economic characteristics of Hispanics and issues of access to health care among this population within the context of cancer prevention and control. [Monogr Natl Cancer Inst 18:1- 9, 1995]

Although the term "Hispanic" was first used to describe persons of Spanish origin more than 2000 years ago, the label gained official acceptance only in recent decades. The federal Office of Management and Budget introduced the term in the 1970s (1), and the U.S. Bureau of the Census first identified persons of "Spanish/Hispanic" origin in 1980. Before 1970, the term rarely appeared in U.S. statistics or in public discourse. Health data on other minority populations, particularly blacks and Asians, have been collected for decades, but compilation of information about Hispanic Americans is fairly recent (2). Currently, the census tabulates demographic information on the 24 million-plus Americans (3) under the broad "Hispanic" umbrella: persons of Mexican, Puerto Rican, Cuban, Central and South American, and "other Hispanic" origin, including Spaniards and Dominicans.

Implied in the Hispanic classification is the existence of commonality in traits, characteristics, and background. To the extent that members of this population trace their roots to one of the Latin American countries or to the European peninsula that became Spain and Portugal, this is true. The implicit homogeneity of Hispanic Americans, however, is dispelled by the notable differences among the various His-

panic groups. Hispanics belong to all races—white as well as black, Asian, and Native American. Indeed, the Hispanic population reflects diversity not only in race, but also in nationality, ethnicity, culture, religion, socioeconomic status, and social class.

This review examines the demographic and socioeconomic characteristics of Hispanics and issues of access to health care among this population within the context of cancer prevention and control.

Historical Perspective

Origins of the Hispanic Americans can be traced to southwestern Europe's Iberian Peninsula, named for the prehistoric Iberian people. Ancient cultures, seeking trade and conquest, contributed to the racial mix of latter-day Spaniards. These cultures included Romans, Germans, Celts, and Jews. Among the strongest influences was that of the Muslims, whose centuries of rule over Spain drew to a close in the late 1400s, ushering in the Christian Era.

During the early period of exploration in the New World, throughout the 16th century, the Spanish were a dominant force. Conquistadors and missionaries were the major players in an exhaustive pursuit of treasure and territory. They encountered and gained control over native populations of what is now the southwestern United States, Mexico, Central and South America, and the Caribbean Islands. To ensure domination of the peoples inhabiting this new land, mixed marriages were encouraged. As a result of extensive racial interaction, modern-day Hispanic Americans represent a blend of diverse civilizations, including those of the Mayans, Incas, Aztecs, Toltecs, Caribs, and other Native Americans.

The Spaniards' entry into the New World began in 1492 in what are now the islands of the Bahamas, Española (Dominican Republic), and Cuba and began a year later in Pu-

*Affiliations of authors: A. G. Ramirez, R. Villarreal, Department of Family Practice, South Texas Health Research Center, The University of Texas Health Science Center at San Antonio.

L. Suarez, Associateship for Disease Control and Prevention, Texas Department of Health, Austin.

E. T. Flores, Center for Studies of Ethnicity and Race in America, University of Colorado at Boulder.

Correspondence to: Amelie G. Ramirez, Dr.P.H., Department of Family Practice, South Texas Health Research Center, The University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Dr., BCT 280, San Antonio, TX 78284-7791.

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erto Rico. All these lands were discovered by Christopher Columbus, as was the continent of South America on his third voyage, when he reached the coast of Venezuela in 1498. In ensuing years, Spanish culture was introduced throughout Central and South America, Mexico, and the southern United States. The oldest settlement under the American flag is San Juan in Puerto Rico (settled in 1521), where the island natives and, later, imported West Africans were bound into slavery (4). A decade earlier, the Spaniards were founding settlements in Cuba, where African slave labor also was introduced.

The early European explorers introduced diseases, such as smallpox, that decimated indigenous populations in numerous parts of the New World. As a result of this large-scale population decrease, the ensuing migration of the Spanish and other Europeans made it likely that a major portion of the current gene pool in particular areas would be composed of Caucasoid genes. For example, of Mexican-origin peoples who have immigrated to south Texas, 61% of the gene pool is Caucasoid, 31% is Amerindian, and 8% is Negroid. Also, the admixture of Amerindian genes in Puerto Ricans and Cuban-Americans is considerably lower than the proportion of genes derived from West Africans.¹

By the mid-16th century, Spanish exploration had crossed the territory that would become the southern United States, from Florida to the Gulf of California. Efforts on another front had brought the Aztec, or Mexica, civilization under the Spanish crown. By the 1780s, more than half of the present United States was under Spanish control. The purchase of the Louisiana Territory from France in 1803 gave U.S. citizenship to thousands of the region's inhabitants, including Hispanics.

In Mexico, the Spanish Colonial Period lasted 300 years, until independence was fought for and won in 1821. The portion of Mexico that was to become Texas gained sovereignty and eventual admission to the Union. Today, Hispanics in Texas number more than 4 million, or more than one fourth of the state's population; of these, 90% are of Mexican origin.

In 1848, the Treaty of Guadalupe Hidalgo allowed the United States to absorb the northern regions of Mexico, consisting of California, New Mexico, Arizona, and parts of Nevada, Colorado, Utah, and Wyoming. The acquisitions resulted in American citizenship for more than 80,000 Mexicans (5). At the end of the 19th century, Spanish control in the New World diminished further, when Cuba gained independence. After the Spanish-American War, many Cubans migrated to the United States. As a further result of that war, the United States took control of Puerto Rico from Spain and, in 1917, granted U.S. citizenship to all Puerto Ricans.

To flee from poverty and their country's political and economic instability, many immigrants from Mexico crossed into the United States during the early 20th century (4). Traced from Mexico's revolution of 1910, immigration, both legal and illegal, continues on a large scale. *Braseros*, or temporary workers, came to the United States in the period 1942-1964, and many stayed.

Similarly, the promise of prosperity has attracted large numbers of Puerto Ricans and Cubans over the years. The Communist takeover of Cuba in 1959 resulted in a dramatic flight to freedom, and most Cuban immigrants settled in Florida's Miami area. Political instability in Central and South American nations during the 1980s also produced a large influx into the United States (6,7). Today, political and economic turmoil in Cuba spawns a steady stream of new immigrants. An agreement with the Cuban government in 1994 will allow 20,000 immigrants from that country into the United States each year.

Although attention is focused on the rising number of Hispanic immigrants, almost two thirds of all Hispanic Americans were born in the United States (3). Nearly three quarters are native-born or naturalized citizens. About 67% of Mexican-Americans were born in this country, and another 7.5% became citizens after arrival here. Among Cuban-Americans, 64% are native-born or naturalized compared with 46% of South Americans and 36% of Central Americans. A large proportion of Central Americans immigrated during the 1980s, thus not living in the United States long enough to complete the naturalization process (3).

Geographic Distribution

Hispanics are found in all 50 states, but the vast majority (84%) reside in eight states (Fig. 1) (8). More than half live in California and Texas and are primarily Mexican in origin. Another 33% of the total Hispanic population are divided among New York, Florida, Illinois, New Jersey, Arizona, New Mexico, Colorado, and Massachusetts. Among states in which Hispanics constitute the highest percentage of the state's populations, New Mexico ranks at the top. Nearly four of every 10 New Mexicans are of Hispanic origin. In California and Texas, that figure is one in four. Hispanics make up more than 10% of the population in eight states, including Arizona (18.8%), Colorado (12.9%), New York (12.3%), Florida (12.2%), and Nevada (10.4%). Mexican-Americans are concentrated in the Southwest and Midwest, Cuban-Americans in the Southeast (primarily in Florida), and Puerto Ricans in the Northeast.

More Hispanic Americans (90.4%) live in metropolitan areas (8) than non-Hispanics (76.2%). More than half of all Hispanics reside in central cities, compared with 30% of non-Hispanics. The largest single concentration of Hispanics, almost 5 million, is found in the Los Angeles Consolidated Metropolitan Statistical Area (CMSA). Fig. 1 shows the Hispanic totals in the Los Angeles CMSA, New York CMSA (almost 3 million), and 10 other metropolitan areas.

When planning health programs, it is important to take into consideration the geographic distribution of the Hispanic population. This distribution reflects waves of immigration representing differences in education, socioeconomic backgrounds, and employment. Such differences in personal characteristics may in turn have an impact on cancer incidence, which may vary among the different Hispanic populations and their geographic distribution (9).

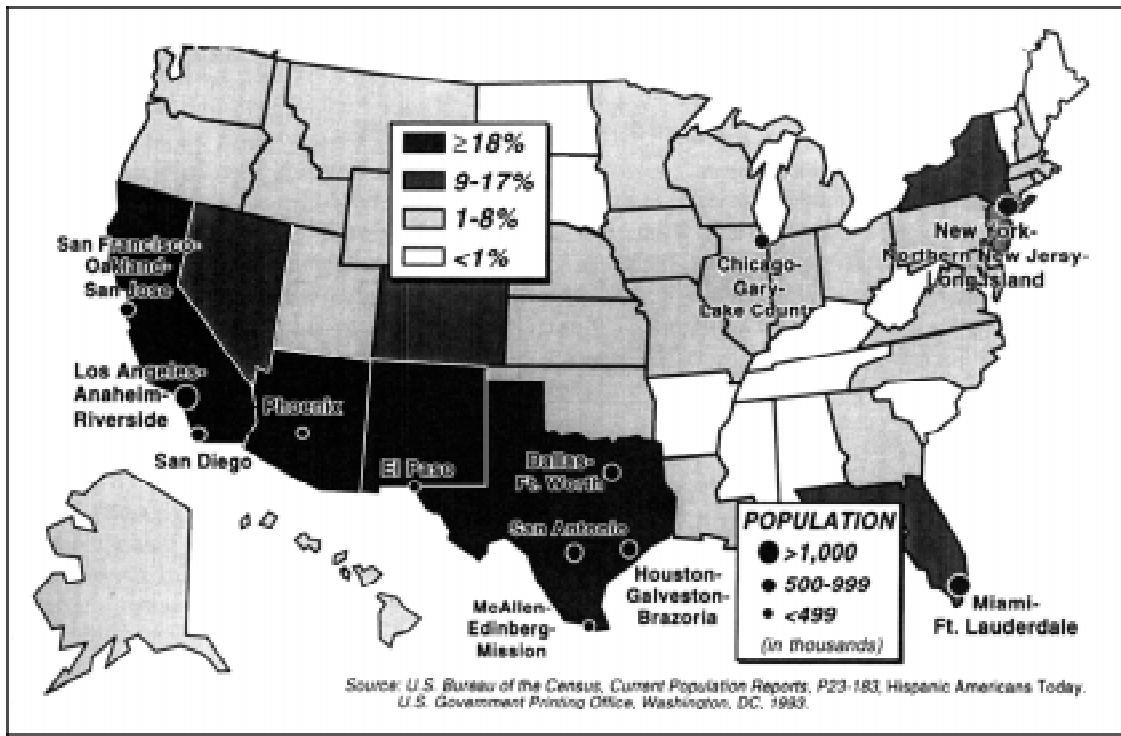


Fig. 1 Percent Hispanic of total population, by state, with selected metropolitan areas.

Demographic Data and Trends

The Hispanic population has several distinguishing demographic features. High rates of immigration and fertility place the Hispanic population among the fastest growing segments in the United States and make this the youngest ethnic group in the country. In education and economic status, Hispanics lag behind other populations. Demographers forecast continued fast growth and low educational and income levels among Hispanics. From 1950 to 1980, the Hispanic population ballooned by 265%, compared with a growth increase of 50% for the total U.S. population (12). From 1980 through 1990, the Hispanic proportion of the U.S. total grew from 6.4% to 9% (8). During the 1980s, al-

most 40% of all immigration to the United States was from Latin America (13). The most dramatic increases were in California, where the Hispanic percentage of the state's population rose 6.6%. Within the next few years, the proportion will likely approach 40% of the state's total (14).

With a population of more than 13 million, Mexican-Americans make up more than 60% of the Hispanic total. Puerto Ricans constitute the second largest Hispanic group (about 12%), followed by Central Americans, Cuban-Americans, and South Americans (Fig. 2).

These proportions reflect overall Hispanic growth rates of 61% during the 1970s and 53% in the 1980s (Fig. 3). Contributing significantly to this growth was the large

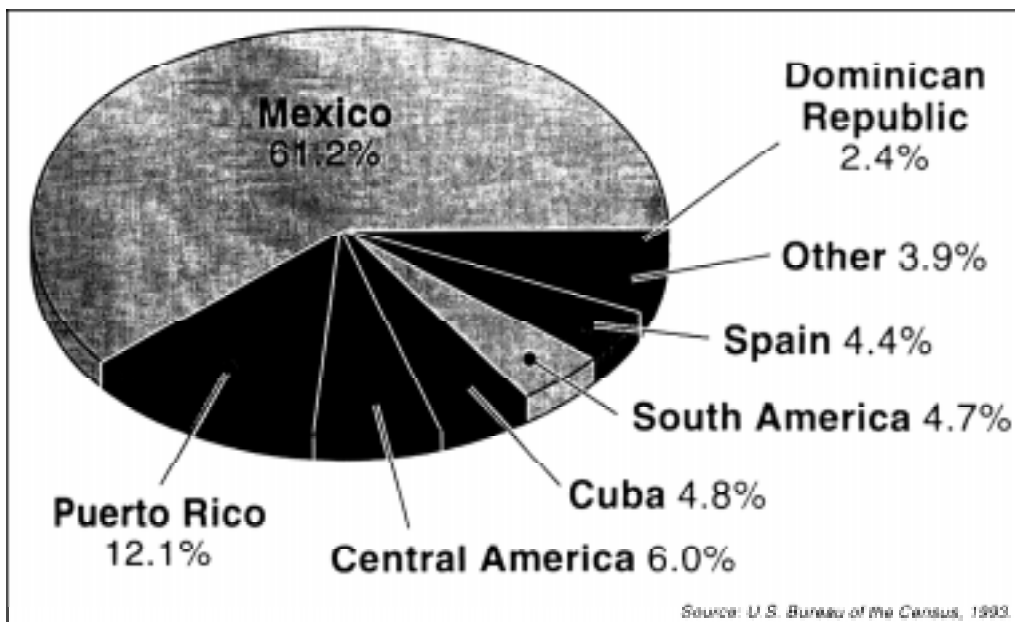


Fig.2 U.S. Hispanic population by origin

increase in Mexican-Americans (93%) from 1970 to 1980; this proportion dropped to 54% from 1980 to 1990. High growth was also seen in Hispanics from Central and South America, whose numbers grew by 67% during the 1980s. By the end of this decade, the U.S. Hispanic population is projected to exceed 30 million, making it the largest ethnic population in the country. By the year 2030, the number of Hispanics is expected to double and to constitute about 17% of the U.S. population (8).

Age, Education, and Income

The Hispanic population is young (Fig. 4). About 60% of all Hispanics are under 30 years of age, as opposed to 44% of

non-Hispanic whites. The proportion of non-Hispanic whites older than age 55 (22%) is twice as high as that of Hispanics.

In 1990, the median age among Hispanics was 26.2 years (15), 8 years younger than non-Hispanic whites (16). Mexican-Americans (median age, 24.3 years) represented the youngest population, compared with 26.7 years for Puerto Ricans, 27.9 years for Central and South Americans, 39.3 years for Cuban Americans, and 31.0 years for other Hispanics (15).

In the analysis of youth growth trends, long-term projections foresee a threefold increase in Hispanics under age 18 nationwide from 1982 to 2020 (17). Over the same time span, the non-Hispanic white youth population is expected

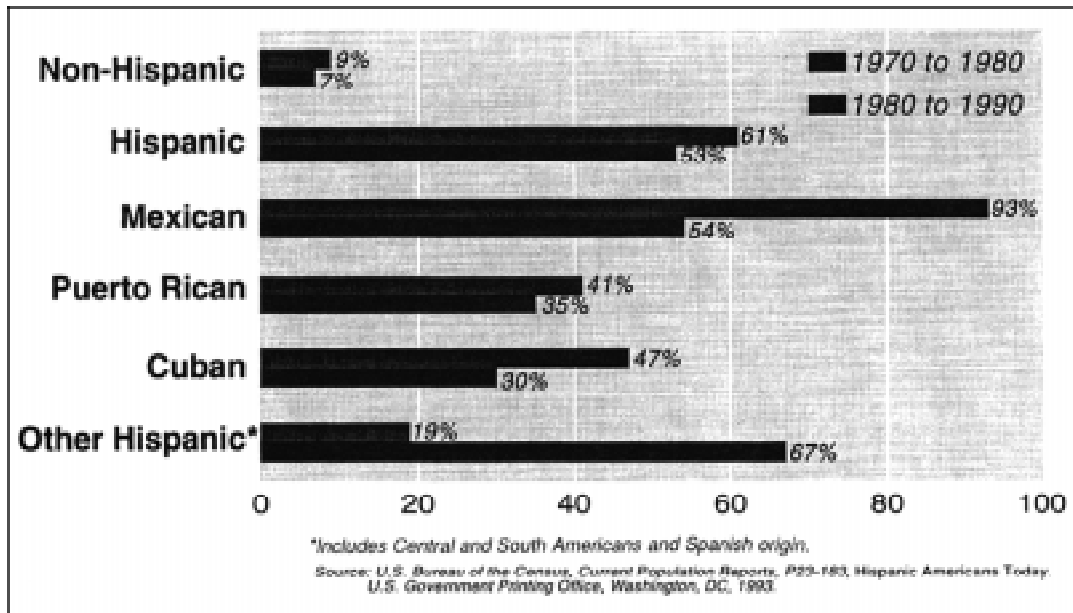


Fig. 3 Percent Hispanic of total population growth by origin, 1970-1990

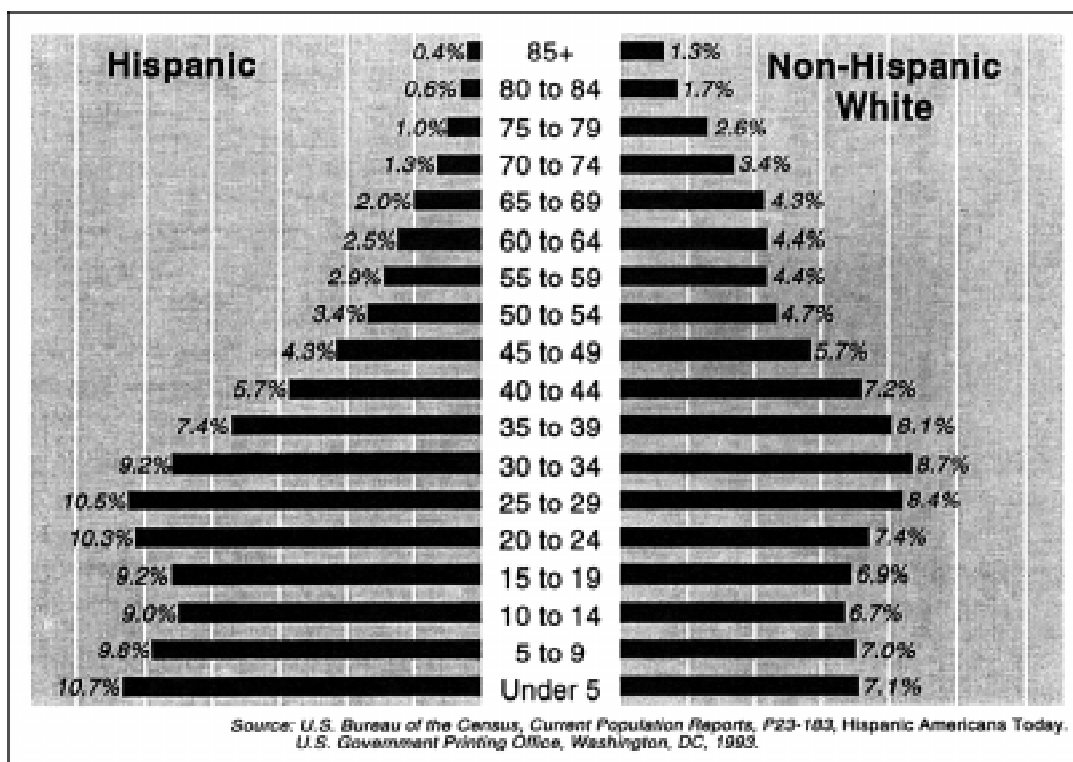


Fig. 4 Age of the Hispanic population compared with the non-Hispanic white population.

to drop 13%. It is projected that, by the year 2020, one in four youths in this country will be Hispanic.

While the Hispanic youths increase in number, the same is true among older members of the population. Hispanics represent the fastest growing segment of the elderly population in the United States. The proportion of older Hispanics, however, is still relatively small, according to 1990 census data (15). About 5% of Hispanics were 65 years old or older, compared with 13% of non-Hispanics. Among the subgroups, the highest percentage of persons in this age category was found among Cuban-Americans (about 15%). Only 3% of Central Americans and South Americans, 4.4% of Mexican-Americans, and 4.7% of Puerto Ricans were 65 years old or older (15).

Although educational levels among Hispanics have improved in recent years, a wide gap remains between Hispanics and non-Hispanics (Table 1). Less than half of all Hispanics aged 25 years or older have completed high school, compared with about 77% of non-Hispanics (15).

Educational problems are most acute among Mexican-Americans, with only a 38.8% high school graduation rate. Education rates of other Hispanic groups are better, although still below those of non-Hispanics. High school graduation levels are 50.5% for Puerto Ricans, 55.8% for Cuban-Americans, 59.1% for Central and South Americans, and 67.2% for other Hispanics (15). Almost 10% of Hispanic adults have 4 or more years of college; this is less than half the proportion for non-Hispanics (21.3%). Mexican-Americans represent the lower end of the spectrum as well, with 5.4%, compared with 17.9% of Cuban-Americans, 15.9% of Central and South Americans, 9.3% of Puerto Ricans, and 16% of other Hispanics (15).

The difference in income levels between Hispanics and non-Hispanic whites is considerable (Table 1). Hispanic men have the highest labor force participation rate among all male population groups, yet more than one fourth of Hispanics live in poverty, and the median annual family income is about \$22,000 (15): These figures contrast sharply with those for non-Hispanic whites: 9.5% of families living in poverty and a median annual household income of about \$32,000 (18). The poverty rate is highest for Puerto Rican families (37.5%)

and lowest for Cuban Americans (13.8%). Although the percentage of male and female civilians in the U.S. labor force is approximately the same for Hispanics and non-Hispanics, the unemployment rate for persons aged 16 years or older is higher for Hispanics (10% than for non-Hispanics (6.9%) (15).

Family Characteristics and Language

During the past 30 years, the average size of Hispanic household has decreased (19). The mean number of persons per family among Hispanic homes is 3.8 versus 3.1 for non-Hispanic whites (17) (Table 2). In contrast, the average for Cuban-Americans is 2.8 (9). The overall Hispanic mean is driven higher by Mexican-Americans (4.1 persons per family) In all, about 29% of Hispanic families have five or more members, compared with 13% of non-Hispanic families (15).

Recent research (19) and census data challenge the presumption long held by many that Hispanic families are more stable than non-Hispanic families. A study of 1980 census results reported higher rates of marital disruption (divorce and separation) for Puerto Ricans than for non-Hispanic whites, with only negligible differences in levels among Mexican-Americans, Cuban-Americans, and non-Hispanic whites (20). Among Mexican-Americans and Cuban-Americans, research suggests that levels of educational attainment and marital instability show correlation, while the reverse is true among Puerto Ricans (21).

Consequently, the percentage of households headed by females with no spouse present is significantly higher among Hispanics than among non-Hispanic whites (24% versus 14%) Among Hispanic groups, Puerto Ricans have the highest percentage of female heads of household, and Mexican-American households have the lowest (Table 2). Almost one in twelve Hispanic families headed by females alone is living below the poverty level, compared with about 32% of non-Hispanics. The situation is even more dire among Puerto Ricans, whose rate is about 64% for families in which females head the household (15).

Eight in 10 Hispanic persons speak Spanish rather than English at home (3) (Table 2). The largest proportion who

Table 1. Percent education/income/labor force of Hispanics compared with non-Hispanic whites

	Non-Hispanic white	All Hispanics	Mexican-American	Puerto Rican	Cuban-American	Central and South American	Other Hispanic origin
Education							
<5 y of school*	2.0	15.9	21.0	11.0	9.8	10.1	7.2
≥4 y of high school	77.4	47.4	38.8	50.5	55.8	59.1	67.2
≥4 y of college	21.3	9.5	5.4	9.3	17.9	15.9	16.0
Income							
Families below poverty level, %	9.5	25.0	25.0	37.5	13.8	22.2	19.4
Median income	\$31,945 [*]	\$22,330 [*]	\$22,439 [*]	\$16,169 [*]	\$25,900 [*]	\$23,568 [*]	\$25,635 [*]
Labor force participation	65.5	65.4	65.6	52.8	64.1	70.3	64.5

*Source: U.S. Bureau of the Census, Current Population Reports: The Hispanic Population in the United States: March 1991. Series P-20, No. 455, Washington, D.C.: U.S. Govt. Print. Off., 1991.

Source: U.S. Bureau of the Census, Current Population Survey, March 1991.

Source: Statistical Record of Hispanic Americans, 1993.

Table 2. Family characteristics of Hispanics compared with non-Hispanic whites

	Non-Hispanic white	All Hispanics	Mexican-American	Puerto Rican	Cuban-American	Central and South American	Other Hispanic origin
Average family size*	3.3	3.8	4.06	3.37	2.81	3.81	3.38
Married couple with family, %*	79.4	69.3	73.5	52.4	76.1	66.1	65.2
Female head of household (no spouse), %†	14	23.8	19.1	43.3	19.4	26.1	27.5
Speak Spanish at home, %‡	0	82.9	68.0	70.5	85.0	89.8	85.4

*Source: U.S. Bureau of the Census, Current Population Reports: The Hispanic Population in the United States: March 1991. Series P-20, No. 455, Washington, D.C.: U.S. Govt. Print. Off., 1991.

†Source: U.S. Department of Health and Human Services, Surgeon General's National Workshop in Hispanic/Latino Health: Public Health Regions VI and VII, San Antonio, Tex., March 22-23, 1993.

‡Source: Statistical Record of Hispanic-Americans, 1993.

speak Spanish at home was found among Central and South Americans, with about 90% in that category. In addition, about 85% of Cuban-Americans and persons of other Hispanic origin said they preferred to speak Spanish at home.

Access to Health Care

For various reasons, Hispanics have limited access to regular health care. A large percentage of Hispanics are uninsured (Table 3). Many seek health care in public facilities, such as hospital emergency rooms, which are overloaded and overextended. The shortage of both Hispanic health care providers and Spanish-speaking and culturally sensitive health professionals is acute. In addition, language and cultural differences present barriers for many families.

As noted earlier, most Hispanics are concentrated in urban areas in which hospitals, clinics, and other health facilities are located. However, they are not receiving care that is early, adequate, or comprehensive. Hispanics also underutilize preventive services, including breast examinations, Pap smears, and blood pressure checks. Because of these and other factors, Hispanics are at greater risk for serious health problems and present with advanced diseases and complications (22).

Lack of private and public insurance is a critical factor for millions of Hispanics. Many Hispanics are among the "working poor," who receive no employer-subsidized health insurance. In other instances, they have access to group insurance but cannot afford the premiums to cover themselves and their families. While 13% of non-Hispanic whites are uninsured, one third of the Hispanic population falls into this category. The figures are even higher for Mexican-Americans (36% uninsured) and Central and South Americans (40%), while about 24% of Cuban-Americans lack insur-

ance. Only 14% of Puerto Ricans are uninsured because of the high proportion of families receiving Medicaid (35%) (23). Uninsured Hispanics are less likely to 1) have a regular source of health care, 2) have visited a physician in the past year, 3) have received a routine physical examination, and 4) rate their health status as excellent or very good (24).

More than one fourth of the country's Hispanics are eligible for Medicaid, yet in 1991 only 17% received this assistance (22). This situation can be attributed partially to the fact that states with high concentrations of Hispanics typically exercise stringent eligibility criteria. In addition, as former Surgeon General Novello noted, "In a culture dominated by honor and pride, there is a pervasive fear of getting involved in a health care system where the language is not understood, where the forms are too long and where the people behind the windows may seem to be judging more than caring" (22).

The impact of many access indicators, such as lack of health insurance coverage, lack of linkage with regular sources of health care, and other system-related and sociocultural barriers, hinders a large proportion of Hispanics from gaining early access to cancer prevention, diagnosis, and treatment.

Underrepresentation of Hispanics in health-related fields is also a major issue. The 1990 Hispanic population constituted 9% of the nation's total; however, less than 5% of all U.S. physicians and only 5.6% of all first-year students enrolled in U.S. medical schools were Hispanic. Mexican-Americans, who make up almost two thirds of the Hispanic population, account for only 1.7% of total medical school enrollment. In addition, the proportion of Hispanics in the fields of dentistry, nursing, and pharmacy is between 2.5% and 3.5% (25).

Table 3. Percent insurance coverage of Hispanics compared with non-Hispanic whites*

Coverage, % Insurance	Non-Hispanic white	All Hispanics	Mexican-American	Puerto Rican	Cuban-American	Central and South American	Other Hispanic origin
Private	77	48	45	42	53	46	57
Medicaid	7	18	13	35	8	10	13
Medicare	14	6	4	6	14	3	7
Uninsured	13	32	36	14	24	40	21

*Source: Labor Council for Latin American Advancement and National Council of La Raza, Hispanics and Health Insurance Vol 1: Status. March 1992.

Class and Race Issues

A basis for understanding the Hispanic population's limited access to health care can be found in its general socioeconomic class standing. Indeed, class issues affect access to care not only for Hispanics, but also for all Americans. For example, "the mortality rate for heart disease in blue-collar workers (operators) was 2.3 times higher than the rate in managers and professionals" (26). Being born into a family with a lower level of education, occupational standing, and income often limits one's life chances and access to the goods of society throughout the life cycle (27). Particularly harmful are effects of a high high school dropout rate among Hispanic youth. The "pipeline effect" ultimately results in small proportions of Hispanic college graduates and even lower percentages of college graduates in the health care professions.

Racial factors also act as barriers to health care. User-friendly, culturally sensitive, and responsive health care systems have not yet been fully conceptualized, developed, and diffused to present patients with personal and caring interactions in a familiar language. Cultural competency training for health care personnel can help combat racist, discriminatory actions and attitudes based on stereotypes and ignorance of important cultural attributes (28,29).

Cancer Mortality Rates

Collection and tabulation of health data regarding Hispanics are inadequate. Hispanics are more prone to diseases such as diabetes, tuberculosis, and acquired immunodeficiency syndrome than non-Hispanic whites (9). However, although heart disease and cancer are the two leading causes of death for Hispanics, their rates are lower than those for non-Hispanic whites (9).

National mortality statistics from 1986 to 1988 showed lower cancer death rates among Hispanics than among non-Hispanic whites (30). For lung cancer, the age-adjusted death rate per 100,000 population in Hispanics was 36.3 for men and 11.9 for women, as opposed to 80.7 in non-Hispanic

white males and 32.1 in non-Hispanic white females. Breast cancer mortality rates among women were 16.6 for Hispanics and 30.7 for non-Hispanic whites. Colorectal cancer death rates were 13.6 for Hispanic men and 27.9 for non-Hispanic white men and 8.9 for Hispanic women and 19.4 for non-Hispanic white women. The death rate from cervical cancer, however, was higher among Hispanic women (4.7) than among non-Hispanic whites (2.7).

In a study of selected geographic sites for the National Hispanic Leadership Initiative on Cancer: En Acción, rates of mortality from various cancers were collected. Statistics reflected death rates among Mexican-Americans in San Antonio and Brownsville, Tex., as well as among Mexican- and Central Americans in San Francisco and San Diego, Calif. Comparative figures for other cities in the study were not available because of differences in data-collection techniques.

Statistical analysis from the four Texas and California metropolitan areas showed an overall lower death rate from cancer of all anatomic sites among Mexican-Americans and Central Americans in comparison to their non-Hispanic white counterparts.² Differentials in death rates for men and women varied among geographic areas. Table 4 shows rate ratios of age-adjusted death rates from leading cancers for Hispanics compared with non-Hispanic whites. Cancer mortality among Hispanics compared with that among non-Hispanic whites was 40%-50% lower in San Francisco, 30% lower in San Diego, and 20% lower in San Antonio and Brownsville. Much of the difference can be attributed to lower death rates from cancers of the lung, breast, prostate, colon, esophagus, urinary bladder, and oral cavity. For example, lung cancer mortality rates in all four cities were more than 60% lower among Hispanic women and 40%-60% lower among Hispanic men. Comparable figures for breast cancer showed a 50% deficit for Hispanic women in California and a 30% deficit in Texas. However, higher rates of death from cancers of the stomach, liver, and gallbladder were reported for Hispanics, and Hispanic women also were at high risk of death from cancers of the cervix and thyroid.² In Texas, Mexican-American females are twice as likely to die of cervical

Table 4. Rate ratios of age-adjusted cancer mortality rates for Hispanics compared with those for non-Hispanic whites*

Cancer site	Rate ratio					
	San Antonio		San Diego		San Francisco	
	Males	Females	Males	Females	Males	Females
All sites	0.8	0.8	0.7	0.7	0.6	0.5
Esophagus	0.6	0.5	0.7	0.3	0.5	0.5
Stomach	1.9	1.6	1.8	2.4	1.5	1.7
Colon	0.6	0.8	0.5	0.6	0.5	0.6
Rectum	1.7	1.6	0.5	0.6	0.8	0.5
Liver	2.8	3.0	1.4	1.5	1.9	2.0
Gallbladder	2.0	4.4	4.0	5.3	1.6	0.1
Lung	0.6	0.4	0.6	0.4	0.4	0.3
Urinary bladder	0.6	0.5	0.6	0.9	0.5	0.3
Breast		0.7		0.5		0.5
Uterine cervix		2.9		2.6		1.2
Prostate	0.5		0.8		0.5	
Testis	0.3		0.7		0.7	

*Source: National Hispanic Leadership Initiative on Cancer: Incidence, Mortality and Behavioral Risks Among Hispanics, 1993.

cancer than non-Hispanic white women (31). Rates of death from stomach cancer were 50% higher in San Francisco Hispanics and more than twice as high in Hispanic women in San Diego. For liver cancer, Texas Hispanics showed rates three times higher than those found in non-Hispanic whites. In addition, women had a particularly higher risk of gallbladder cancer than men, with rates four to five times higher in Texas and San Diego.²

Discussion

Hispanic demographic trends will certainly hold implications for our nation's ability to reduce cancer mortality and promote general health. This population is growing faster than other major sectors, and high birth and immigration rates ensure a continuation of this growth. Although at present this population is very young, it is aging, and the elderly segment is increasing in size. Hispanics also rank low in terms of education and income among major components of the U.S. population. Additional factors include the low health status in relation to the rest of the nation, the large proportion of uninsured families, and the otherwise poor access to health care. These distinct demographic characteristics and barriers have a direct impact on the risk for cancer in Hispanics and on the development of prevention and control strategies.

Largely because of the high growth rate and the low educational and income levels, the image of an underclass erroneously influences our health policy toward Hispanics (2). In some areas of the country, this population is viewed as either a drain or a threat to society. Important demographic and health statistics, however, counter the popular notion of the Hispanic underclass model. Mortality rates for most causes of death are lower for Hispanics than for non-Hispanic whites. Overall life expectancy is higher for Hispanics. In Los Angeles, the incidence of low birth-weight babies is lower among Hispanics, and neonatal and infant mortality rates are about half those of non-Hispanic whites (32). In addition, the high rate of men in the work force and the disproportionately low participation of women in government-subsidy programs do not fit common Hispanic stereotypes and further erode the underclass model as applied to this population. Such data clearly indicate that this model provides an inappropriate base for public policy (2).

Some evidence suggests that increased acculturation may have competing health consequences for Hispanics. It has been suggested (2) that, as this population more closely assumes the lifestyle of "mainstream" society, Hispanics will adopt health behaviors—good and bad—of non-Hispanic whites. On the positive side, this means greater likelihood of participation in cancer-screening procedures and of obtaining private health insurance. In contrast, it also may result in increased consumption of alcohol and tobacco among segments of the population, particularly among Hispanic women, who historically have reported lower smoking and drinking rates than their non-Hispanic white counterparts.

Certainly, the need exists for precise and timely health data specific to each Hispanic population group. Indeed, if trends for this population include increased levels of acculturation, edu-

cation, and socioeconomic status, it is important to understand the health implications of these changes. We also need to understand reasons for positive behaviors commonly exhibited and to formulate policies and programs that encourage and maintain these lifestyle choices. At the same time, more research is necessary to gain greater insight into Hispanic health problems and direct culturally effective education and prevention efforts. It is also vital to the success of these endeavors that we recognize the diversity that exists among the ethnic components of this population and resist the temptation to make broad policy generalizations. In addition, special efforts to understand the risk behaviors of new immigrants, particularly Central and South Americans, are needed. It may be helpful to examine cancer data sources from the Pan American Health Organization or the World Health Organization on cancers most common to the immigrants' countries of origin.

Major gaps exist in current collection, analysis, and dissemination of data related to Hispanic health. The need exists for a more supportive infrastructure vital to the development and implementation of research programs. We need to look at current data-collection instruments and procedures, to assess their effectiveness, and to develop innovative strategies better suited to Hispanics. Significant national data-collection systems should include statistically valid samples for the Hispanic population and its major components. In basic, applied, and clinical studies, ways must be found to involve more Hispanic researchers and to improve cross-cultural competence of non-Hispanic researchers. More epidemiologic studies should focus on causal factors and consequences and the mechanisms through which they function. Also, greater Hispanic representation is necessary on grant review committees, as well as in leadership and advisory positions at all levels of research development, program planning, and program implementation.

Specific to cancer issues, more funding is needed for research and control efforts in the Hispanic population. Increased epidemiologic research would enable us to better understand the disease in this population and learn why certain cancers are more prevalent in Hispanics than in non-Hispanic whites, while others are less prevalent. We also have insufficient data concerning the effectiveness of cancer treatment in Hispanics and how these treatment procedures affect quality of life. Additional insight into the influence of cultural and demographic considerations with regard to Hispanic participation in cancer control efforts and other health programs is needed. To increase awareness and invalidate misconceptions, greater effort should be directed at optimal ways to disseminate information about cancer risk factors and the importance of personal behavior in fighting this disease.

While Hispanic mortality rates are lower than those among non-Hispanic whites for major cancers, such as lung and breast cancers, epidemiologic evidence indicates that rates of death from these diseases are on the rise (30). However, these and other noncommunicable diseases prevalent among non-Hispanic whites have not yet fully emerged in the Hispanic population. For this reason, the opportunity exists for primordial pre-

vention or action to prevent the adoption of lifestyles and other conditions that would likely result in increased incidence of noncommunicable diseases. For Hispanics, effective primordial prevention efforts would link higher education and affluence levels to the assimilation of positive health behaviors rather than negative behaviors of the dominant culture. For example, strong education and health promotion campaigns should be implemented in a culturally appropriate context that would discourage smoking and drinking but would encourage exercise, proper nutrition, and preventive care. Optimal results can be achieved by enlisting local participation in combined efforts of individuals, institutions, and community organizations.

In addition to adopting strong research, education, and prevention measures, it is absolutely essential that we find the resolve and the means to eliminate barriers that Hispanics face in obtaining health care. That one third of this population lack any form of health insurance should not be acceptable in our society. Health insurance coverage should be comprehensive, affordable, secure, open to choice, unbiased to existing conditions, and culturally responsive. The need exists for a more equitable distribution of health care providers, particularly those who are Hispanic and bilingual, in inner city and rural areas that are traditionally underserved. We need to intensify efforts to provide easily accessible, user-friendly, and nondiscriminatory health services throughout the country.

The consequences of inaction in adopting effective health care reform that addresses these issues can be measured in various ways. The consequences of not adopting a comprehensive health plan would include the continued upward spiral of medical costs for society as a whole, the burden placed on public health facilities and personnel, increased political conflict over access to quality health care, and, most importantly, the price of human suffering among those who can least afford to pay.

In conclusion, researchers must have a thorough understanding of the Hispanic population's diversity with regard to demographics, geographic distribution, acculturation levels, and barriers to health care to develop and implement cancer prevention and control research that is meaningful and that can be delivered in a culturally appropriate manner.

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