The Impact of Structural Factors on the Health of Latinos

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As of 2011, the United States reported spending $2.7 trillion on health care, or 17.9 percent of the national Gross Domestic Product (Centers for Medicare and Medicaid Services, 2013). However, the health outcomes of the American people suggest that something has gone awry in this investment. The World Health Organization (WHO) has published a ranking of 191 countries based on the overall efficiency of each nation's health care system. The report measured efficiency based on each nation's ability to meet five goals: maximizing population health, minimizing health inequality, increasing level of responsiveness to patients' needs, increasing equitable responsiveness distribution among all patients, and fair financing. According to the 2001 report, the United States was ranked 37th (Tandon, Murray, Lauer & Evans, 2001). Despite health expenditure rates that are much higher than many other developed nations, the health status of many within American borders is far from satisfactory. The health outcomes of minority groups are consistently worse than those of the majority population in the United States, and although minority health is generally improving, the health of Latinos specifically is deteriorating. Moreover, Latinos are less likely than non-Latino Whites to receive specific health services and treatments that would benefit their overall health status (Stone & Balderrama, 2008).

With the growing Latino population in the United States, Latino health concerns affect the nation as a whole. Data from the 2010 Census reports that Latinos currently make up 16 percent of the national population. Furthermore, while the total national population increased by 10 percent, the Latino population specifically grew by 43 percent (Ennis, Rios-Vargas & Albert, 2011). Clearly, this is a minority group whose presence in the nation is steadily increasing. With Latino population rates expected to continue rising, it is imperative to the overall physical health of the nation to explore and understand the structural factors contributing to adverse Latino

health. Moreover, improving Latino health would also positively impact the nation's economic and social health, as economic productivity is likely to increase with healthier workers. By addressing the disparities of a vulnerable group, the nation would demonstrate genuine concern and respect for its residents, thereby improving the social health of the nation through increased community participation and sense of national belonging.

Documentation of health disparities within the Latino population in the United States is plentiful (Kaplan & Inguanzo, 2011; Stone & Balderrama, 2008; Zambrana & Dill, 2006). However, there is a lack of understanding of the causes of this widening gap. Traditional public health and medical approaches focus on individual responsibilities and self-care as the primary causes of health disparities, but evidence suggests that structural inequalities significantly contribute to the creation and continuation of these disparities (Quesada, Hart & Bourgois, 2011; Zambrana & Dill, 2006). As one may expect, the causes of Latino health disparities are misunderstood because of a lack of research that focuses on this group. Although the impact of socioeconomic standing on health status has been explored, oftentimes race and ethnicity are left out of the equation. This can be due to several factors. For instance, historically surveys and questionnaires have not included Hispanic or Latino as a possible demographic identifier (Homan, Homan & Carrasquillo, 2010). Furthermore, the heterogeneity within the Latino population has not been explored. Those who identify as Latinos may have very different countries of origin, race, ethnicity, and socioeconomic status. Understanding the characteristics of this population, including its complex heterogenic makeup, is of crucial importance to comprehending the impact of structural inequalities on the health of the community. There is clearly a need for increased research focusing on the specific health concerns of Latinos in the

United States, which will in turn shed light on the causes of the health disparities plaguing this group.

Understanding the roots of health inequity is also confounded because not only is there a wide range of structural inequalities that impact Latinos, but also most factors seem to interact with each other to produce a combined effect that is much greater than that of any particular factor. For this reason, it is difficult to separate individual contributing inequalities, and inaccurate to discuss each only as a separate entity. This paper will therefore focus on each factor in an attempt to explain its contribution to the overall structural violence that perpetuates adverse Latino health. The individual contributing factors include health literacy, language preference, lack of employment benefits, housing and environmental racism, and provider racism as they relate to the health of Latinos in the United States.

Structural Violence

Structural violence is a term used to describe the systematic way in which social structures produce inequality. It is considered violence because it is a way through which powerful structures, institutions, and policies maintain control over specific populations and marginalize them by preventing them from meeting their basic needs. This is also considered deliberate violence because it is avoidable. Oftentimes, the poor health conditions that result from structural violence could have been prevented if inequity was not perpetuated by the powerful. The idea of structural violence has been attributed to Johan Galtung, but has become a salient focus in medical anthropology (Galtung, 1969). For example, medical doctor and anthropologist Paul Farmer often uses the term to describe the political and historical factors still inflicting suffering on the poor in Haiti. He argues that in order to carry out structural violence,

dominant groups largely use the erasure of history as a weapon to facilitate the imposition of the injustices caused. Farmer uses the story of how the HIV/AIDS virus really entered Haiti as an example. He explains that in reality, the virus entered Haiti via foreign (oftentimes American) sex tourists, but the truth has been replaced with a story blaming the slaves taken from Africa (Farmer, 2001). In this example, the powerful have erased and altered history in order to create support and evidence in their quest to establish the Black poor as somehow inferior.

Farmer also includes cultural relativism as a tool used to perpetrate structural violence. He claims that too often medical anthropologists focus over heavily on the cultural beliefs of those affected and use that as an excuse to maintain distance between themselves and those who are suffering. Although Farmer does not deny the existence of cultural differences, he claims that the influence of these differences on health disparities is often overemphasized. The cultural distance created by these exaggerations allows medical anthropology to perpetuate inequality by attributing disparities largely to cultural differences (Farmer, 1996). Instead, Farmer calls for an increased effort in identifying axes of oppression and addressing those directly. Furthermore, these axes of oppression are best understood when presented within the appropriate political, historical, and economic context. With this recommendation in mind, it is of importance to review the historical background of the Latino population in the United States.

Immigrant Background

Although the United States has always been a popular destination for immigrants worldwide, since the 1960s the majority of those immigrants have come from Latin America and Asia (Stone & Balderrama, 2008). The term Latino is understood to describe people born in or descending from Mexico, Puerto Rico, Cuba, Central America, South America, or the Caribbean

(Ennis, Rios-Vargas & Albert, 2011). Latinos that immigrate to the United States are characterized as being young and productive. Few are the Latino immigrants who are very young or very old. Rather, the majority are of working age and are therefore self-sustaining. Furthermore, it has also been noted that these young immigrants tend have more children than non-Latino White families (Bodvarsson & Van den Berg, 2009).

The history of Latino, specifically Mexican, immigration can be traced back to the years of the Bracero program. The Bracero program entailed a series of agreements between the Mexican and United States governments made in 1942. President Franklin D. Roosevelt's administration was afraid that because of World War II, there would not be enough farm laborers to harvest the crops. Therefore, agreements were made that would allow for Mexican farm workers to be contracted in the United States between 1942 and 1947. The program was under the jurisdiction of the Department of Agriculture and guaranteed minimum living and working conditions for the immigrants (Scruggs, 1963). However, this governmental regulation was burdensome for both the Mexican workers and the American farmers. This created an increasing number of illegal immigrants known as "wetbacks", who would make private arrangements with American farmers and thereby avoid the hassles of the Department of Agriculture (Martin, 2004). The broken system continued on past its original termination date until it was finally ended in 1964. The United States saw only a slight increase in illegal immigration with the close of the Bracero program, and it was not until the 1990s when Mexican and other Latino immigration would significantly increase (Quesada, Hart & Bourgois, 2011).

In 1994 the North American Free Trade Agreement (NAFTA) went into effect, allowing for open trade without tariffs between Mexico, the United States and Canada. This was expected to create new jobs in Mexico, decreasing the amount of illegal immigrants entering the United

States in search of work (Martin, 2004). However, this was not the case. Because the foreign money now entering Mexico was not used to develop domestic business, the economy collapsed. This severely impacted crop prices and rather resulted in increased illegal immigration of Mexican farmers to the United States (Bodvarsson & Van den Berg, 2009). Therefore, although the NAFTA was intended to create economic opportunity in Mexico, and many promoted a decrease in illegal immigration as a positive side effect, reality proved to be the opposite. This surge of Mexican immigration into the United States began the tremendous period of Latino growth that is still seen today.

As of 2005, Mexicans made up about 30% of all foreign-born immigrants in the United States (Bodvarsson & Van den Berg, 2009). This is a very significant amount for just a single country of origin, but can be understood in light of the historical relationship between the two countries. According to the 2010 US Census, Latinos of Mexican origin made up 63% of the total Latino population in the nation (Ennis, Rios-Vargas & Albert, 2011). Clearly, the geographic proximity, as well as the economic and historical ties discussed, have had lasting effects on Mexican immigration and the Latino makeup of the United States.

Educational Attainment and Health Literacy

With this historical and demographic background in mind, the health disparities of the Latino community may be analyzed at the intersection of several factors that put the group at a disadvantage. One of the most salient factors contributing to low health status is lower levels of education. The educational disparities faced by the Latino community are an issue with a level of complexity that is comparable to that of health disparities. The complexity results because there is not one single cause but rather each issue is the product of a variety of factors that are

intertwined and often cyclical. With regards to education, Latinos are often at a disadvantage because of socioeconomic status and the chances available in life (Abraido-Lanza, White, Armbrister & Link, 2006). Focusing solely on women, research has shown there is a greater chance of non-Latinas having more education than Latinas. Unfortunately, this is a cyclical problem because low educational attainment is associated with financial problems and limited employment opportunities (Zambrana & Dill, 2006). This in turn contributes to a lower likelihood of upward socioeconomic mobility, and the cycle continues on. Furthermore, factors such as the re-segregation of urban majority/minority schools and the salience of stereotypic beliefs about Latinos can work to limit the academic opportunities and achievements of this community (Dill & Zambrana, 2009). In fact, when compared to non-Latino Whites, Latinos were the most disadvantaged in terms of educational attainment (Center for Disease Control [CDC], 2011). Much like the reality of Latino health disparities, this is a problem in which no improvement was seen between 2005 and 2009 (CDC, 2011).

Educational attainment contributes to Latino health inequities via health literacy levels. Health literacy is used to describe one's ability to obtain and understand health information in order to make well-informed health decisions. Research in this field has produced extensive evidence linking low health literacy with poor health outcomes (DeWalt, Berkman, Sheridan, Lohr & Pignone, 2004). These outcomes broadly include the use of screenings and services, knowledge of conditions, and knowledge of ways to treat or manage disease (Kim, Moran, Wilkin & Ball-Rokeach, 2011). In fact, the importance of increasing health literacy in order to improve health outcomes has been acknowledged by health authorities such as the US Health and Human Service Department's Healthy People 2010 (Kim, Moran, Wilkin & Ball-Rokeach, 2011). Furthermore, a special mention was made in a report by the Institute of Medicine on the

importance of increasing patient education (Nelson, 2002). Health literacy is important to health outcomes because it allows for fluid communication between health service providers and patients (Zambrana & Dill, 2006). Without understanding the terminology used, patients are unable to follow the medical advice given to them or may not even understand exactly what condition they have. High levels of health literacy ease the communication between provider and patient, while those Latinos with low health literacy may not take full advantage of their provider's resources due to a communication barrier.

Several interventions have been proposed to address this problem, especially among the Latino community. For instance, one such program makes use of "*promotoras*", social service assistants from the community that receive training in health literacy. In a study funded by the National Library of Medicine, *promotoras* were trained using a train-the-trainer approach in communities near the Texas-Mexico border (Olney, Warner, Reyna, Wood & Siegel, 2007). Border communities found in Texas, New Mexico, Arizona and California are commonly referred to as "colonias"—the Spanish word for neighborhood. These rural communities, which suffer greatly from poverty, are the site of many *promotora* initiatives (Arizmendi & Ortiz, 2004). In the study, the *promotoras* were trained to use the online resource, MedlinePlus, and worked with community members, teaching them to use the medical website as well. The *promotoras* reported stories of their interactions with the community members and often highlighted resident experiences of understanding, decision-making and increased health knowledge as a result of using MedlinePlus. These findings have implications for future health policy because of the increased health literacy in this medically underserved Latino population. *Promotoras* were successful in interacting with and teaching community members, and were trusted by the community at large (Olney, Warner, Reyna, Wood & Siegel, 2007). This study

shows that training paraprofessionals of this sort to enter vulnerable communities is successful in increasing health literacy. The problem with implementing programs based on this model is funding. For example, at the onset of this study there were three community centers where *promotoras* were working. However, funding problems resulted in only one active program with an available internet connection by the end of the study (Olney, Warner, Reyna, Wood & Siegel, 2007). While these limited resources underscore the accomplishments of the project, there is also a very realistic restraint placed on the success.

Nonetheless, there exist general principles that may be drawn from this approach that proved to be very successful. A similar case study regarding the work of *promotoras* in border communities presented four such principles. However, for the purpose of this paper only two will be analyzed as they may be applied generally to Latino health promotion. The first principle emphasizes the idea of self-determination and allowing communities to decide for themselves what needs to be addressed (Arizmendi & Ortiz, 2004). This concept is useful with regards to Latino health because an outside agent will be much less able to identify the population's needs if the people themselves do not have the necessary terminology or health literacy level to adequately describe their situation. Therefore, employing self-determination principles is crucial to understanding a community's specific needs and increasing health literacy by allowing the community members to better express their concerns.

Another principle drawn from the work of *promotoras* explains the importance of using local resources (Arizmendi & Ortiz, 2004). *Promotoras* are the perfect example of untapped local resources, since they are typically members of the community who are only distinguished by the additional training they receive. Membership in the community is essential because it increases the credibility of the community health worker. Within the colonias, *promotoras* were

able to make strong connections with the community members and earn their trust and respect (Olney, Warner, Reyna, Wood & Siegel, 2007). Without this credibility, it is much more likely that the information imparted would have been rejected. Therefore, although the process of using community health workers to increase health literacy is not without its faults, it is a very successful example of using self-determination and local resources within a community.

Language Barriers

The connections between low educational attainment, low health literacy, and poor health outcomes are clear. However, for some Latinos a lack of understanding of health jargon is not the root cause of their problems. Communication with health care providers can also break down because of a language barrier. As of 2008, 35 million United States residents, aged 5 or older, reported speaking Spanish in the home (US Census Bureau [USCB], 2010). This constitutes 12 percent of the American resident population, and although about half of those who reported speaking Spanish also reported speaking English very well, speaking Spanish is clearly a very important demographic indicator. Within the field of public health, researchers have further identified language use, Spanish or English, as an indicator of a Latino subgroup that is especially vulnerable to poor health. In a study analyzing data from the 2003 Medical Expenditure Panel Survey, the most disadvantaged group was the group that spoke the least amount of English (Cheng, Chen & Cunningham, 2007). This group was characterized by lower education attainment, lower income, and a lack of health insurance. In contrast, the least disadvantaged group was made up of non-Latino Whites. The disadvantaged group was less likely to receive all the health care services for which its members were eligible (Cheng, Chen & Cunningham, 2007). The correlation between language spoken and socioeconomic status is clear because language barriers can limit occupational opportunities and hinder rise in socioeconomic

status. Acculturation or acclimation to the dominant US culture could also play a role in making use of the health care services available (Cheng, Chen & Cunningham, 2007). Furthermore, low English use could also mark undocumented status in an immigrant and seeking services could be prevented by a fear of deportation. Language was indeed found to be an identifying marker for a subpopulation at risk. A study done by DuBard and Gizlice in 2008 supported these findings. Using data from the 2003-2005 Behavioral Risk Factor Surveillance System, Spanish-speaking Latinos were found to be less likely to have access to health care or a personal doctor, and were less likely to utilize preventative services, such as vaccinations. These findings support the claim that language barriers can jeopardize the health outcomes of Latinos because of broken communication between patients and health care service providers.

Occupational Limitations

As mentioned, language barriers and low educational attainment are structural factors that interact with each other to produce lower health outcomes for Latinos in the United States. Language use and education may also hinder economic upward mobility by limiting Latinos to specific types of jobs. These complex interactions between several factors make the intersectional approach used here very useful and appropriate. Though each factor makes a unique contribution to the overall problem, the interactions between factors adds a greater level of complexity and depth that creates a much more realistic representation of Latino health disparities.

Limited occupational opportunity is one such factor that contributes to the overall problem. The labor market in the United States can be divided into two main sections: the “high-tech/high wage and manual/low-wage sectors” (Rumbaut, 2010, p. 17). Each sector in the market

attracts different types of immigrants, depending on the level of education attained and citizenship status. Based on an analysis of data from the 2006 March Supplement of the Current Population Survey, Latinos and other racial minorities were found to be overrepresented in the modest, low-paying jobs (Semyonov, Lewin-Epstein & Bridges, 2011). These jobs are typically not included within a highly regulated sector such as the public sector, but are rather usually day labor, on call, or part-time work. One significant impact of working these low-status jobs is that oftentimes they do not come with health care benefits. Even when socio-demographic factors such as working "off the books" or having immigrant status are accounted for, Latino workers still have lower rates of access to health care benefits. When compared to Whites, Blacks, and Asians, Latinos were the most disadvantaged group because they were much less likely to have health benefits provided by their employer (Semyonov, Lewin-Epstein & Bridges, 2011). This can partly be attributed to the reasons listed above, but not completely. The remaining variable to be considered is race. Remaining racial disparities might be accounted for by discrimination from the employer. Another possible explanation is that Latinos have less bargaining power to negotiate the benefits and terms of employment (Semyonov, Lewin-Epstein & Bridges, 2011). This difficulty could be caused by the large percentage of Latino workers who are undocumented. These workers are often more desperate to find jobs, so they are less likely to demand more from their employer. These complex reasons must also be included in an analysis of the disadvantage of Latino workers in receiving health care benefits.

Access to Health Care

The lack of access to health insurance is a critical factor in explaining poor Latino health. The United States is the only nation in the developed world whose residents are not guaranteed health insurance (Homan, Homan & Carrasquillo, 2010). In 2009, 32.4% of Latinos were not

covered by health insurance compared to 15.8% of Whites, 21% of Blacks and 17.2% of Asians (DeNavas-Walt, Proctor & Smith, 2010). Although these statistics are alarming on their own, the seriousness of the situation is emphasized by the fact that the disparity is worsening for Latinos, even while it is steadily improving for Blacks and Asians (Homan, Homan & Carrasquillo, 2010). As discussed, lack of health care benefits can be intricately connected to the type of employment attained. Those immigrants who are undocumented are much more likely to work off the books or to work in jobs where they do not receive health care benefits. This is supported by findings estimating that up to 80 percent of undocumented Latino residents do not have health care coverage (Homan, Homan & Carrasquillo, 2010). For undocumented residents, the problem is exacerbated by the restrictions that exclude them from government insurance programs such as Medicaid.

The impacts of being uninsured on health outcomes are very grave. Studies have found that compared to insured adults, adults lacking insurance are three times more likely to be hospitalized for treatable illnesses such as diabetes (Kaplan & Inguanzo, 2011). Furthermore, uninsured children are 40 percent less likely to be treated for serious physical injuries than their insured counterparts (Kaplan & Inguanzo, 2011). Moreover, the effects of lacking insurance not only affect ability to receive treatment, but also access to preventative care. While 24 percent of insured Latina women and 53 percent of insured Latino men have never received preventative health services, the same is true for 40 percent of uninsured Latina women and 73 percent of uninsured Latino men (Kaplan & Inguanzo, 2011). Clearly, lacking health insurance has serious ramifications for the health of the uninsured both in terms of treatment and access to preventative care.

The two main predictors of lacking insurance among Latinos in the United States are citizenship status and family income levels. Those caught at the intersection of these two groups, noncitizen Latinos living in poverty, have uninsured rates of 44 percent. This is nearly double the rate for non-Latino Whites in the same income group who lack insurance (Homan, Homan & Carrasquillo, 2010). Limited employment opportunities remain the mediating variable, and show the complexity of the interactions between multiple structural factors. In turn, lacking health insurance benefits can also be accounted for by educational disparities. Because of these interactions, health coverage is ultimately rooted in whether benefits are provided by the employer or not.

It is possible that the Patient Protection and Affordable Care Act passed by the Obama administration will change some of these structural factors that are hindering Latinos' health care access. It is predicted that the new legislation will allow uninsured Americans to buy health insurance from "government-sponsored insurance exchanges that offer sliding-scale financial subsidies to low- and moderate-income families" (Kaplan & Inguanzo, 2011, p. 90). Through this and several other similar changes, it is expected that the new health care system will lower the number of uninsured and thereby improve health outcomes for Latinos and other disadvantaged groups. This will provide Latinos with increased access to preventative care, primary care and access to community health workers that are specifically trained to work with underserved populations. The new legislation will also tackle the problem of health disparities by establishing the Office of Minority Health within the U.S. Department of Health and Human Services to evaluate federal minority health programs (Kaplan & Inguanzo, 2011).

Geographical Distribution

Although strongly influenced by citizenship status and income level, access to health insurance is also correlated with geographical distribution. States with the lowest rates of insurance were found to largely match those states that have the highest Latino population (Homan, Homan & Carrasquillo, 2010). Each individual state has its own restrictions and guidelines that affect eligibility for government health insurance programs. Such differences have the capacity to significantly decrease the amount of Latinos that are able to obtain government health insurance in one state versus another.

The effects of geographical location are profound and extend far beyond Medicaid eligibility. The percentage of Latinos that lives in urban areas exceeds 90 percent, with about 46 percent of those residents living in the central cities within large metropolitan areas (Zambrana & Dill, 2006). Urbanization, while not inherently negative, may bring new challenges that negatively impact the health of its residents. For instance, an increased concentration of populations in metropolitan areas adds pressure to the local infrastructure, and may "force all societies and governments to reconsider policies, interventions and the very socioeconomic indicators by which they measure quality of life" (Kjellstrom, 2008, p. 4). Not surprisingly, the effects of urban health are intricately connected to other structural factors. While urban environments should provide greater opportunities for economic upward mobility, the increased pressure on infrastructure may prevent this from becoming a reality. Therefore, for those Latinos living in urban areas who are unable to overcome poverty, their area of residence further exacerbates their health concerns by allowing for the spread of diseases and infections (Kjellstrom, 2008). Urban areas are often very crowded, resulting in poor hygienic conditions that ease that transmission of disease between residents.

Much like many other groups of immigrants, the geographical distribution of Latinos shows a tendency to cluster, regardless of urban or rural location. This tendency can be explained through social reasons, as immigrants seek networks that will help ease the transition to a new country (Bodvarsson & Van den Berg, 2009). While early Latino immigration was concentrated in the Southwest, California, and Illinois, data from recent years has shown that the Latino presence is spreading throughout the entire nation (Alba, Denton, Hernandez, Disha, McKenzie & Napierala, 2010; Ennis, Rios-Vargas & Albert, 2011). Regardless of region within the nation or urban versus rural environment, it remains that Latinos tend to live in neighborhoods whose residents are primarily Latinos. These Latino neighborhoods have a median household income of $40,000 while the median household income of a non-Latino White neighborhood is $60,000 (Alba, Denton, Hernandez, Disha, McKenzie & Napierala, 2010). While the limiting effects of low income on health outcomes have already been discussed, it is important to note again the complex interactions of several structural factors that together create the current situation of Latino health. These neighborhoods with greater rates of poverty will also be largely inhabited by residents with low educational attainment, which has also been discussed as impinging on health. These factors interact in such complex ways that it becomes nearly impossible to isolate the effect of one factor alone.

Housing and Environmental Health

Oftentimes, geographic factors impact housing and can result in environmental health inequity for Latinos. In recent years, the concept of environmental justice has become an interest of researchers focusing on racial disparities in health. The U.S. Environmental Protection Agency (EPA) emphasizes that environmental justice should ensure equitable treatment for people of all races, colors, national origins and income. This means that no group “should bear a

disproportionate share of the negative environmental consequences resulting from industrial, municipal, and commercial operations, or the execution of federal, state, local, and tribal programs and policies" (Bullard, Johnson, Glenn & Torres, 2011, p. 15). However, modern American society does not represent this environmental ideal. The modern urban environment has been significantly shaped by land-use zoning. Zoning laws are intended to regulate urban land use by designating land to be specifically for residential, commercial, or industrial use (Bullard, Johnson, Glenn & Torres, 2011). However, oftentimes the boards that make zoning decisions are not representative of the communities that are affected. This has allowed zoning and rezoning to become a tool for structural violence. With "not in my backyard" (NIMBY) mentalities, the professional board members are able to essentially limit immigrants, poor people or people of color to inhabit areas where polluting industries operate (Bullard, Johnson, Glenn & Torres, 2011). This creates a group, which includes Latinos, that is very vulnerable to the environmental health risks caused by pollution. In fact, as of 2007 people of color constituted 56 percent of people living within two miles of commercial hazardous waste facilities, but were only 30 percent of the people living in neighborhoods beyond two miles (Bullard, Johnson, Glenn & Torres, 2011). This clearly shows a concentration of ethnic minority communities in the geographical areas that experience the highest health risks due to pollution. Furthermore, despite the rising environmental justice movement, there have been no signs of improvement between the original *Toxic Wastes and Race* report in 1987 and the *Toxic Wastes and Race at Twenty 1987-2007* report, both commissioned by the United Church of Christ (UCC) (Bullard, Johnson, Glenn & Torres, 2011). However, under the Obama administration a greater awareness of environmental justice issues has risen and changes are starting to be seen within the EPA. For instance, in 2009 the EPA began using the Environmental Justice Strategic Enforcement

Assessment Tool to identify geographical regions with high environmental hazards and health risks (Bullard, Johnson, Glenn & Torres, 2011). This is cause for great hope that zoning and industrial pollution will no longer be used as tools of structural violence.

Aside from increased pollution risks due to poor zoning strategies, Latino health can also be negatively impacted by the types of hospitals found in the geographic area. As with many other factors discussed, geographic residence of Latinos is intricately interwoven with other socioeconomic elements. Income levels are highly correlated with geographical residence, and it has been found that 22 percent of poor Latinos live in high-poverty neighborhoods (Satel & Klick, 2006). The hospitals found near these neighborhoods tend to be government-run institutions where there is a high proportion of Medicaid patients. These hospitals, which treat greater numbers of minority patients, generally offer poor quality service. There is often high patient volume, which minimizes the time doctors spend with their patients. The geographical concentration of Latinos in certain regions and the disproportionate poverty status of these neighborhoods result in poorer quality hospitals, compared to hospitals that treat fewer minorities (Satel & Klick, 2006). The intricate connections of several structural factors serve once again to underscore the complexity of Latino health and the very real presence of structural violence.

Another impact environmental health can have on Latino health is with regards to housing. Housing is generally not included in the general public's opinion as being valuable enough to be considered a shared common, such as food or water. Non-Latino Blacks and Latinos seem to be those most impacted by this mentality that devalues adequate housing. According to the American Housing Survey, in 2005 6.3 percent of Latinos lived in moderately substandard housing, compared to 7.5 percent of Blacks and only 2.8 percent of non-Latino

Whites (Jacobs, 2011). Substandard housing can negatively impact health outcomes through adverse physical, chemical, biological, building and equipment, or social conditions. These conditions can range from energy efficiency to carbon monoxide to rodents or hygiene and sanitation issues (Jacobs, 2011). Again, the interdependence between low-income status and substandard housing is clear. The influence of each factor heightens the combined contribution to adverse Latino health.

Provider Racism

The factors discussed thus far have largely been institutional structures that are made up of and supported by a large group of people, namely the majority population. In many of those instances, it is difficult to isolate an individual as a perpetrator, although the structurally violent system only survives with the support of many. Such is not the case with provider racism. Bias is understood to be a negative evaluation of one group compared to another. When these evaluations are made with respect to race, the bias can be more specifically labeled as racism. Racism can be categorized as explicit if the person is aware of their beliefs and supports them or implicit if they are unintentional beliefs (Blair, Havranek, Price, Hanratty, Fairclough, Farley, Hirsh & Steiner, 2013). A recent study measuring both explicit and implicit bias found nearly no evidence of explicit bias. However, implicit bias against Latinos was demonstrated by nearly two thirds of primary care providers in the sample, despite their explicit egalitarian views. Implicit bias was measured using the Implicit Association Test (IAT). This measure asks participants to use a specific response key when a Latino face appears on a screen or when a "bad" word appears, but to use a different response key for a White face or a "good" word. The associations are then reversed, and the same key must be used for Latino faces and good words while a different key is used for White faces and bad words. The results showed that participants

responded significantly faster to Latino faces and bad words, thereby demonstrating the association and implicit bias against Latinos (Blair, Havranek, Price, Hanratty, Fairclough, Farley, Hirsh & Steiner, 2013). The study also explored the racial biases of community members and found no significant differences in the implicit biases against Latinos of providers versus community members (Blair, Havranek, Price, Hanratty, Fairclough, Farley, Hirsh & Steiner, 2013). The negative prejudices and stereotypes that make up racial bias against Latinos ultimately affect the quality of care received by Latino patients. The Institute of Medicine (IOM) has offered several suggestions to combat this contribution to racial health disparities. These recommendations include supporting the community health workers that help patients understand the health care system and implementing the use of language interpretation services. Furthermore, the report notes the underrepresentation of racial minority health professionals, and recommends measures be taken to increase representation (Nelson, 2002). These suggestions are made because provider racism is enhancing the structural violence faced by minorities and taking a serious toll on the health outcomes of Latinos.

However, this view on provider racism is not without dissent. Arguments have been made in the scholarly community as to whether provider bias is truly a contributing factor to racial health disparities or if there may rather be third factors that are associated with race (Satel & Klick, 2006). Third factors include several of the structural factors discussed. This approach would therefore take the blame of racism away from individual providers and place it instead on societal institutions. The conclusions drawn from the IOM report are critiqued, claiming that insufficient background information was included in its claims. Those arguing against the biased-doctor model claim that geographical variations, as well as minority patient characteristics, are more significant in explaining racial health disparities (Satel & Klick, 2006).

Regarding geography, the argument is made that minority patients receive lower care because of the hospitals that are available in low-income neighborhoods. Patient characteristics that also contribute to lower care include health literacy and procedure refusal rates. The IOM report claims that "differences in refusal rates are generally small" and as such do "not fully explain health care disparities" (Nelson, 2002, p. 667). However, opponents argue that patient refusal does make a significant difference, using folk beliefs as evidence to support patient noncompliance. A study done at the Philadelphia Veterans Affairs Medical Center reported that Black patients refused to receive surgical treatment for lung cancer 19 percent of the time, while White patients refused only 5 percent of the time (McCann, Artinian, Duhaime, Lewis, Kvale, DiGiovine, 2005). Although data for the actual participants in the study was not available, the researchers hypothesized that refusal rates are correlated with a folk belief that operations will cause lung cancer to spread, citing research whose rates of belief in this notion were comparable to the refusal rates for each race. Scholars in support of the third-factor model conclude that socioeconomic status and geographical residence are more significant in explaining health disparities than race alone.

The support for both provider racism and structural racism can be observed in the literature. The clear conclusion is that there is a great need for more information on racial health disparities. As discussed, the structural factors contributing to adverse health outcomes of Latinos are many, and the effects of each are compounded. Therefore, the third factor model cannot be discredited. However, evidence can be found for implicit bias in providers, which also negatively impacts Latino health. Further research may be directed not to place one model over the other, but rather to explore the interactions of the two models and their combined effect on minority health.

Conclusion

The impacts of structural factors on Latino health are plenty. Although past research on minority health has placed an emphasis on individual health behaviors, it is clear that structural inequity has a tremendous role in explaining health disparities. According to the wisdom of Dr. Paul Farmer, it is important to fully understand the history and politics of a nation or a group of people before attempting to grasp the causes of their poor health conditions. With a clear understanding of the historical and political ties between Mexico and the United States dating back to the days of the Bracero program, it is appropriate to analyze several structural factors. Dr. Farmer also went on to identify the erasure of history as a tool used in structural violence, giving Haiti as an example. The same tool is used in the United States with regards to Latino immigration. For instance, the American population is largely unaware of the Bracero program or the key role that the United States played in creating the economic hardships facing Mexico via NAFTA. These historical realities are conveniently forgotten by the majority population in order to perpetuate negative stereotypes about immigrants. Without a careful analysis of the historical and political background of Latino immigrants, the nation can ignore the active recruitment that first created a Latino population in the United States. Furthermore, it is only through acknowledging the oppressive treatment historically received by immigrants, including geographical displacement and limiting occupational prospects, that the nation will recognize the ethical obligation to improve the health outcomes of Latinos. Through erasure of these key historical and political happenings, Latinos are depicted by mainstream society as criminals or as somehow less worthy, thereby devaluing the health concerns of this group. With this obstruction of the nation's responsibility, it becomes clear not only how but also why structural factors contribute to the poor health outcomes of Latinos.

Contributing both individually but more impressively through complex interactions, structural factors such as health literacy, language preference, lack of employment benefits, housing and environmental racism, and provider racism negatively impact Latino health. The depth and complexity of the issue can only be appreciated in light of the multiple factors that are used by the majority population as tools to perpetuate structural violence on Latinos via health inequity. It is of great importance to the nation to recognize these factors as such and work towards a more equitable future for all.

Some initiatives have been taken to lessen the effects of these structural factors and have been met with mixed success. Although the educational disparities discussed have not improved in recent years, health literacy among Latinos was successfully enhanced by the work of *promotoras* (Olney, Warner, Reyna, Wood & Siegel, 2007). As mentioned, there may be limitations to implementing the *promotora* model on a large-scale, but there are several lessons to be learned from its past success. The contribution of language barriers to communication breakdowns between patients and providers may be alleviated by increasing the amount of minority or bilingual providers. This would increase the likelihood that the provider and the patient speak the same language (Nelson, 2002). Furthermore, because language spoken identified a subgroup of Latinos that is especially vulnerable to poor health, policies should address the specific needs of this at-risk group.

Access to health care has been addressed by the Affordable Care Act, although its success has yet to be determined. It is expected that the impacts on uninsured groups such as Latinos will be positive (Kaplan & Inguanzo, 2011). Housing and environmental racism could be effectively addressed by promoting more representative zoning boards. If the boards are truly representative of their communities, then the needs of all community groups will be heard and

considered. Lastly, as discussed, the issue of provider racism has no clear definition. Further research into the area will allow for better directed initiatives. However, this issue could again be combated by increasing the number of providers from minority populations (Nelson, 2002).

Although there remain several large factors that have yet to be addressed, progress has been made on others. The poor health of Latinos in the United States is a very complex problem and as such requires a complex solution. An important first step towards reaching health equity is gaining a greater understanding of the factors that contribute to poor health outcomes. This new awareness, combined with the successful policies discussed, create a reason to hope for a more equitable future regarding health in the United States.

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