

MULTICULTURAL HEALTH

FOURTH EDITION

LOIS RITTER & DONALD H. GRAHAM



Multicultural Health

Multicultural Health

FOURTH EDITION

Lois Ritter

Public Health Consultant

Donald H. Graham

Attorney and Consultant, Health Care

Bassim Hamadeh, CEO and Publisher
Amanda Martin, Executive Publisher
Amy Smith, Associate Editorial Manager
Rachel Kahn, Production Editor
Emely Villavicencio, Senior Graphic Designer
Alexa Lucido, Senior Licensing Manager
Stephanie Adams, Senior Marketing Program Manager
Natalie Piccotti, Director of Marketing
Kassie Graves, Senior Vice President, Editorial
Alia Bales, Director, Project Editorial and Production

Copyright © 2027 by Cognella, Inc. All rights reserved. No part of this publication may be reprinted, reproduced, transmitted, or utilized in any form or by any electronic, mechanical, or other means, now known or hereafter invented, including photocopying, microfilming, and recording, or in any information retrieval system without the written permission of Cognella, Inc. For inquiries regarding permissions, translations, foreign rights, audio rights, and any other forms of reproduction, please contact the Cognella Licensing Department at rights@cognella.com.

Trademark Notice: Product or corporate names may be trademarks or registered trademarks and are used only for identification and explanation without intent to infringe.

Cover image copyright © 2023 iStockphoto LP/Alessandro Biascioli.
Interior image copyright © 2023 iStockphoto LP/Alessandro Biascioli.

Printed in the United States of America.

This book is designed to provide educational information and motivation to our readers. It is sold with the understanding that the publisher is not engaged to render any type of psychological, legal, diet, health, exercise or any other kind of professional advice. The content of each chapter or reading is the sole expression and opinion of its author, and not necessarily that of the publisher. No warranties or guarantees are expressed or implied by the publisher's choice to include any of the content in this volume. Neither the publisher nor the individual author(s) shall be liable for any physical, psychological, emotional, financial, or commercial damages, including, but not limited to, special, incidental, consequential or other damages. Our views and rights are the same: You are responsible for your own choices, actions, and results and for seeking relevant topical advice from trained professionals.



To Emma and Samantha, for the love and laughter

—LR

To Sarah

—DG

Brief Contents

Preface	xvii
-------------------	------

UNIT I The Foundations 1

Chapter 1	Introduction to Multicultural Health	2
Chapter 2	Multicultural Health Frameworks and Assessments	32
Chapter 3	Worldview and Health	56
Chapter 4	Complementary and Alternative Medicine	86
Chapter 5	Public Health	109

UNIT II Cultures in the United States 141

Chapter 6	Hispanic Americans	149
Chapter 7	American Indians/Alaska Natives	175
Chapter 8	Black Americans	204
Chapter 9	Asian Americans	233
Chapter 10	White Americans	256
Chapter 11	Nonethnic Cultures	283
Chapter 12	The Macro Cultures Related to Health and the Health Care System	322

UNIT III Looking Ahead 343

Chapter 13	Closing the Gap: Addressing Health Disparities	344
	Glossary	358
	Index	365
	About the Authors	376

Detailed Contents

Preface xvii

UNIT I	The Foundations	1
CHAPTER 1	Introduction to Multicultural Health.	2
	Key Concepts and Terms	2
	Learning Outcomes	3
	Multicultural Health Terminology and Concepts	4
	Culture	4
	Race and Ethnicity	5
	Ethnocentricity and Cultural Relativism	10
	Cultural Adaptation	10
	Diversity Within the United States	13
	Health Disparities	13
	Causes of Health Disparities	15
	Environmental Exposures	17
	Genetics	18
	Lifestyle	19
	Social Circumstances	19
	Medical Care	20
	Legal Protections for Minorities	21
	Ethical Considerations	26
	Summary	27
	Review	28
	Activities	28
	Case Study 1	28
	Case Study 2	29
	References	30
CHAPTER 2	Multicultural Health Frameworks and Assessments.	32
	Key Concepts and Terms	32
	Learning Outcomes	32
	Theories of Health and Illness	33
	Personalistic Theories	34

Naturalistic Theories	35
Biomedical Theory	38
Pathways to Care	38
Allopathic Medicine	39
Holistic Medicine	40
Cultural Models	40
The Process of Cultural Competence in the Delivery of Health Care Services	41
The Purnell Model for Cultural Competence	41
Sunrise Model	43
The 5 Rs of Cultural Humility: A Conceptual Model for Health Care Leaders	44
Cultural Assessments	45
Individual Assessment of Cultural Competence	46
Organizational Assessment of Cultural Competence	46
Summary	53
Review	53
Activities	53
Case Study 1	54
Case Study 2	54
References	55
CHAPTER 3 Worldview and Health.	56
Key Concepts and Terms	56
Learning Outcomes	56
Overview of Worldview	57
Major Facets of Worldview	57
Temporal Relationships	58
Personal Space	58
Social Organization	58
Communication	61
Health Decisions	64
Beginning-of-Life Decisions	64
End-of-Life Decisions	66
Mental Health Decisions	70
Response to Illness	70
Religion	75
Religion in the United States	76
Religion and Health Behaviors	76

Dietary Practices	77
Use of Stimulants and Depressants	78
Rituals	79
Objects as Rituals	80
Shrines	80
Animal Sacrifice	80
Birthing Rituals	80
Death Rituals	82
Summary	82
Review	83
Activities	83
Case Study 1	84
Case Study 2	84
References	85
CHAPTER 4 Complementary and Alternative Medicine	86
Key Concepts and Terms	86
Learning Outcomes	86
History and Utilization of Complementary and Alternative Medicine	88
Complementary and Alternative Health Care Modalities	91
Ayurvedic Medicine	91
Yoga	92
Traditional Chinese Medicine	92
Naturopathy	96
Herbal Remedies	97
Reiki	98
Meditation	100
Laws Affecting Cultural Practices and Health	101
Unlicensed Practices	101
Dietary Supplements	103
Summary	104
Review	105
Activities	105
Case Study 1	105
Case Study 2	106
References	107
CHAPTER 5 Public Health	109
Key Concepts and Terms	109

Learning Outcomes 109

Health Communication 110

Literacy 116

 Fry Readability Graph 117

Delivering Your Health Message 118

 Electronic Communication Channels 119

 Nonelectronic Communication Channels 122

 Promotores and Community Health Workers 124

Public Health Planning Models 125

 Planning Models 125

Public Health Program Design 128

 Mobilizing Communities to Move in Coeur d’Alene Tribe, Idaho 129

 Improving Tobacco-Free Environments in the Pacific Islands 129

 Healthy Corner Store Initiative in Central Alabama 129

 Fruit and Vegetable Prescription Program in the Navajo Nation 130

Program Evaluation in a Multicultural Context 130

Summary 138

Review 138

Activities 138

Case Study 1 139

Case Study 2 139

References 140

UNIT II Cultures in the United States 141

Socioeconomic Data by Race/Ethnicity 142

Health Behaviors by Race/Ethnicity 143

Nonethnic Cultures 147

CHAPTER 6 Hispanic Americans. 149

Key Concepts and Terms 149

Learning Outcomes 149

Introduction 150

Terminology 150

History of Hispanic Americans in the United States 151

Hispanic Americans in the United States 152

General Philosophy About Disease Prevention and Health Maintenance ... 154

 Worldview 154

 Pregnancy, Birth, and Childrearing 155

Nutrition and Exercise	156
Mental Health	157
Death and Dying	159
Cultural-Bound Illnesses	159
Healing Traditions and Healers	161
Healers	162
Curanderos	162
Santeria	162
Espiritismo	163
Behavioral Risk Factors and Common Health Problems	164
Considerations for Health Programs and Working With	
Hispanic Americans	166
Summary	169
Review	169
Activities	170
Case Study 1	170
Case Study 2	171
References	171
CHAPTER 7 American Indians/Alaska Natives	175
Key Concepts and Terms	175
Learning Outcomes	175
Introduction	176
Terminology	176
History of American Indian/Alaska Natives in the United States	177
American Indians/Alaska Natives in the United States	178
General Philosophy About Disease Prevention and Health Maintenance	181
Worldview	182
Pregnancy, Birth, and Childrearing	183
Nutrition and Exercise	183
Mental Health	185
Death and Dying	186
Cultural-Bound Illnesses	186
Healing Traditions and Healers	187
Healing Ceremonies	188
Healers	190
Plants and Herbs	192
Dancing	194
Behavioral Risk Factors and Common Health Problems	194

Considerations for Health Programs and Working With American Indians/Alaska Natives	197
Summary	199
Review	199
Activities	199
Case Study 1	200
Case Study 2	200
References	200
CHAPTER 8 Black Americans	204
Key Concepts and Terms	204
Learning Outcomes	204
Introduction	205
Terminology	205
History of Black Americans in the United States	205
Black Americans in the United States	210
General Philosophy About Disease Prevention and Health Maintenance	212
Worldview	212
Pregnancy, Birth, and Childrearing	213
Nutrition and Exercise	214
Mental Health	214
Death and Dying	216
Cultural-Bound Illnesses	216
Healing Traditions and Healers	217
Behavioral Risk Factors and Common Health Problems	219
Considerations for Health Programs and Working With Black Americans	224
Summary	226
Review	227
Activities	227
Case Study 1	227
Case Study 2	228
References	229
CHAPTER 9 Asian Americans	233
Key Concepts and Terms	233
Learning Outcomes	233
Introduction	234
Terminology	234

History of Asian Americans in the United States	235
Asian Indian Americans	235
Chinese Americans	235
Japanese Americans	236
Korean Americans	236
Vietnamese Americans	236
Asian Americans in the United States	237
General Philosophy About Disease Prevention and Health Maintenance	238
Worldview	240
Pregnancy, Birth, and Childrearing	242
Nutrition and Exercise	243
Mental Health	244
Death and Dying	244
Cultural-Bound Illnesses	244
Healing Traditions and Healers	246
Risk Factors and Common Health Problems	247
Considerations for Health Programs and Working With Asian Americans	249
Summary	250
Review	251
Activities	251
Case Study 1	251
Case Study 2	252
References	252
CHAPTER 10 White Americans	256
Key Concepts and Terms	256
Learning Outcomes	256
Introduction	257
Terminology	257
History of White Americans in the United States	258
White Americans in the United States	259
General Philosophy About Disease Prevention and Health Maintenance	261
Worldview	261
Pregnancy, Birth, and Childrearing	261
Nutrition and Exercise	263
Mental Health	263
Death and Dying	263
History, Healing Practices, and Risk Factors for Three Subcultures	264

Amish Americans	264
Roma Americans	268
Arab and Middle Eastern Americans	270
Behavioral Risk Factors and Prevalent Health Problems	274
Considerations for Health Programs and Working With White Patients	275
Summary	277
Review	278
Activities	278
Case Study 1	278
Case Study 2	279
References	279
CHAPTER 11 Nonethnic Cultures	283
Key Concepts and Terms	283
Learning Outcomes	283
Introduction	284
People With Disabilities	284
Terminology	284
Behavioral Risk Factors and Common Health Problems Among People With Disabilities	285
Considerations for Health Promotion and Program Planning for People With Disabilities	287
Hired Farmworkers	288
History of Farmworkers in America	289
Hired Farmworkers in the United States	289
Behavioral Risk Factors and Common Health Problems Among Farmworkers	291
Considerations for Health Promotion and Program Planning for Farmworkers	292
Immigrants and Refugees	292
Terminology	293
Behavioral Risk Factors and Common Health Problems Among People Who Are Immigrants or Refugees	294
Considerations for Health Promotion and Program Planning for People Who Are Immigrants or Refugees	294
Users of Drugs	295
Behavioral Risk Factors and Common Health Problems for Users of Drugs	298

Considerations for Health Promotion and Program Planning for Users of Drugs	299
LGBTQIA	299
Terminology	300
Behavioral Risk Factors and Common Health Problems Among LGBTQIA	301
Considerations for Health Promotion and Program Planning for LGBTQIA	303
Rural Residents	304
Terminology	305
Behavioral Risk Factors and Common Health Problems Among Rural Residents	305
Considerations for Health Promotion and Program Planning for Rural Residents	308
Generations	308
Terminology	309
Behavioral Risk Factors and Common Health Problems Among Generations.	310
Considerations for Health Promotion and Program Planning for Generations.	311
Summary	314
Review.	315
Activities	316
Case Study 1.	316
Case Study 2	316
References	317
CHAPTER 12 The Macro Cultures Related to Health and the Health Care System . . .	322
Key Concepts and Terms	322
Learning Outcomes	322
Introduction	323
Terminology	324
Consumers and Their Health	325
Social Classes and Health	328
The Upper Class.	329
The Middle Class.	329
The Lower Class.	330
Capitalism and Health	331
Behavioral Risk Factors and Common Health Problems	332

Consideration for Health Promotion and Program Planning 335

Changing Views of Health Care: Establishing a Culture of Health 336

Summary 337

Review 338

Activities 338

Case Study 1 338

Case Study 2 339

References 340

UNIT III Looking Ahead 343

CHAPTER 13 Closing the Gap: Addressing Health Disparities 344

Key Concepts and Terms 344

Learning Outcomes 344

 Government-Documented Initiatives 345

Strategies From the Field 348

 Increase Cultural Competence and Humility 348

 Target Research 350

 Maximize Environmental Justice 351

 Increase Access to Health Care 352

 Improve Quality of Care 353

 Build Health for All Into Policies and Laws 353

Summary 354

Review 355

Activities 355

Case Study 1 355

Case Study 2 356

References 356

Glossary 358

Index 365

About the Authors 376

Preface

Your mind is like a parachute. ... It functions only when open.

—AUTHOR UNKNOWN

Health care professionals work in a diverse society that presents both opportunities and challenges, so cultural competence and humility are essential to their roles. Although knowing about every culture is not possible, understanding cultural variations can improve effectiveness and outcomes. *Multicultural Health* provides an overview of the major perspectives and behaviors that stem from culturally based worldviews.

Throughout this text, those engaged in health care can acquire the necessary knowledge to improve their engagement with individuals and communities with varied backgrounds. This book equips readers to navigate the complexities of providing culturally sensitive health care and delivers practical guidance for those working in the field.

About This Book

Multicultural Health is divided into three units. Unit I, “The Foundations,” includes Chapters 1 through 5 and focuses on the context of culture, cultural beliefs regarding health and illness, health disparities, theories and models relevant to cross-cultural health and communication, and approaches to culturally appropriate health promotion programs and evaluation.

- Chapter 1, “Introduction to Multicultural Health,” discusses the reasons for becoming knowledgeable about the cultural impact of health practices. It defines terminology and key concepts that set the foundation for the remainder of the text. The chapter describes diversity in the United States and the racial makeup of the country, health disparities and their causes, laws designed to protect minorities, and ethics.
- Chapter 2, “Multicultural Health Frameworks and Assessments,” addresses theories regarding the occurrence of illness and its treatment. Terms and theoretical models related to cultural competence and humility are provided. Individual and organizational cultural assessments are included.
- Chapter 3, “Worldview and Health,” explores perspectives on illness, treatment, and influences that affect health decisions. Differences in worldview and how they affect perceptions about health, health behaviors, treatment pathways, and interactions with health care providers are described. Verbal and nonverbal communication considerations are explained, as well as how worldview influences specific areas of health, such as beginning-of-life decisions. The chapter then focuses on religion and rituals as related to health.

- Chapter 4, “Complementary and Alternative Medicine,” introduces complementary and alternative medicine and health practices. It explores the major non-Western medicine modalities of care, including Ayurvedic medicine, traditional Chinese medicine, herbal medicine, and holistic and naturopathic medicine. History, theories, and beliefs regarding the source of illness and treatment modalities are described.
- Chapter 5, “Public Health,” includes information about culturally sensitive communication strategies used in public health. Considerations for creating health care messages and selecting communication channels, such as social media, for diverse audiences are explained. Information about health and digital literacy and public health models are included, as well as examples of culturally designed programs and strategies to evaluate programs with diversity in mind.

Unit II, “Cultural Groups,” includes Chapters 6 through 12:

- Chapter 6: Hispanic Americans
- Chapter 7: American Indians/Alaskan Natives
- Chapter 8: Black Americans
- Chapter 9: Asian Americans
- Chapter 10: White Americans
- Chapter 11: Nonethnic Cultures
- Chapter 12: The Macro Cultures Related to Health and the Health Care System

Chapters 6 through 10 are organized by race and ethnicity, while Chapter 11 focuses on nonethnic cultures such as the rural population. Each chapter includes the history of the subject population in the United States and its current status, beliefs regarding the causes of health and illness, healing traditions and practices, common health problems, and health promotion and program planning. Chapter 12 describes the overarching commercial and economic health culture in the United States that affects everyone in the country.

Unit III, “Looking Ahead,” outlines priority areas in health disparities and strategies to reduce/eliminate them. Chapter 13, “Closing the Gap: Addressing Health Disparities,” explores the documented government strategies for reducing or eliminating health disparities as well as those from the research and insights from the authors.

New to This Edition

Statistics, laws, and health information have been updated and/or added throughout the book. A second activity has been added to all chapters, along with a critical thinking section named “What Would You Do?” The authors reduced the amount of COVID-19 information and replaced it with examples of more current events. A data section has been added at the beginning of Unit II that highlights health disparities. Here are some examples of the modifications made to each chapter:

- Chapter 1: Added information about changes on how race, ethnicity, and gender information is collected and reported by federal agencies. The suggestion of using social drivers instead of social determinants of health is introduced.
- Chapter 2: Retitled chapter to improve alignment with the content. Added the 5 Rs of Cultural Humility model.
- Chapter 3: Added information about the effects of worldview at the community level and two new sections about worldview and decisions related to (a) mental health and (b) assisted reproduction.
- Chapter 4: Expanded information about cannabis and added the “gas station heroin” Tianeptine.
- Chapter 5: Added information about digital literacy. Reorganized the communication section into electronic and nonelectronic and added information about culture and color in communications. A new section titled “Public Health Program Design” was added. This new section includes examples of public health programs that integrate cultural preferences, practices, and beliefs into the interventions.
- Chapters 6–10: Added a data section to the Unit II preface. The chapters were renamed and the learning outcomes and review questions have been updated and made consistent across the unit. A map of where the subject population resides, a mental health section, and a chart of top 10 causes of mortality were added to each chapter. The quick facts sections have been reorganized into five areas where the population has better outcomes than other populations and five areas with worse outcomes. Examples of chapter-specific changes include these:
 - Chapter 6: Removed the Hispanic paradox, added Latine to terminology.
 - Chapter 7: Expanded/added healing circles, skin walkers, and mutton.
 - Chapter 8: Culture-bound illnesses (e.g., sleep paralysis) and long-COVID death information were added.
 - Chapter 9: Incorporated information such as violence against the Asian population due to COVID-19 and expanded areas such as Timbang and culture-bound illnesses.
 - Chapter 10: Added information to terminology, health data about the Roma, and the new Census population category called Middle Eastern and North African (MENA).
- Chapter 11: Added information about the Appalachian culture, the One Big Beautiful Bill Act, and Gen Alpha and expanded areas such as the LGBTQIA terminology section.
- Chapter 12: Graphs illustrating costs prohibiting access to care and how the United States health outcomes compare to other countries were incorporated; sections such as the health culture of the social classes were expanded.

- Chapter 13: Renamed and divided into two sections: government-based initiatives and strategies from the field. Updated health equity strategic plans, including adding the Centers for Medicare and Medicaid Services, the Medicaid framework for health equity 2022–2032, and the National Institutes of Health Minority Health and Health Disparities strategic plan 2021–2025. Added information about cultural humility, environmental justice, mapping tools, and artificial intelligence.

Features and Benefits

Each chapter includes a “Did You Know?,” “What Do You Think?,” and “What Would You Do?” section to stimulate critical thinking and classroom discussions. Also included are chapter review questions, related activities, and two case studies. Key concepts are listed, and their definitions are provided in the glossary.

We hope the information contained in *Multicultural Health* will introduce you to the rich and fascinating cultural landscape in the United States and the diverse health practices and beliefs of cultural groups. This book is not intended to be an end point; rather, it is a starting point in the journey to becoming culturally competent and practicing cultural humility in health care.



UNIT I

The Foundations

- CHAPTER 1** Introduction to Multicultural Health
- CHAPTER 2** Multicultural Health Frameworks and Assessments
- CHAPTER 3** Worldview and Health
- CHAPTER 4** Complementary and Alternative Medicine
- CHAPTER 5** Public Health

Introduction to Multicultural Health

We have become not a melting pot but a beautiful mosaic.
—JIMMY CARTER

One day our descendants will think it incredible that we paid so much attention to things like the amount of melanin in our skin or the shape of our eyes or our gender instead of the unique identities of each of us as complex human beings.
—AUTHOR UNKNOWN

KEY CONCEPTS AND TERMS

Acculturation	Dominant culture	Minority
Assimilation	Ethics	Multicultural health
Autonomy	Ethnicity	Morality
Beneficence	Ethnocentricity	Nonmaleficence
Cultural adaptation	Fidelity	Race
Cultural competence	Health disparity	Racism
Cultural humility	Healthy People 2030	Respect
Cultural relativism	Heritage consistency	Stereotype
Culture	Hill–Burton Act	Veracity
Discrimination	Justice	

LEARNING OUTCOMES

After reading this chapter, you should be able to do the following:

1. Explain why cultural considerations are important in health care.
2. Define *race, culture, ethnicity, ethnocentricity, cultural relativism, cultural competence, cultural humility, stereotype, and discrimination*.
3. Explain cultural adaptation and why it is important in health care.
4. Explain what health disparities are and their related causes.
5. List the five elements of the determinants of health and describe how they relate to health disparities.
6. Explain key legislation related to health and minority rights.

Why do we need to study multicultural health? Why is culture important if we all have the same basic biological makeup? Isn't health all about science? Shouldn't people from different cultural backgrounds just adapt to the health care system and perspectives in the United States?

For decades, the role that culture plays in health was virtually ignored, but the links have become more apparent. As a result, the focus on the need to educate health care professionals about the important role that culture plays in health has escalated. Health is influenced by factors such as diet, the environment, and socioeconomic status, as well as by other cultural and social forces. Culture affects people's perception of health and illness, how they pursue and adhere to treatment, their health behaviors, beliefs about why people become ill, how symptoms and concerns about the problem are expressed, what is considered a health problem, and ways to maintain and restore health. Recognizing cultural similarities and differences is an essential component for delivering effective health care services. To deliver quality care, health care professionals need to provide services within a cultural context, which is the focus of **multicultural health**.

Multicultural health is the phrase used to reflect the need to provide health care services in a sensitive, knowledgeable, and nonjudgmental manner with respect for people's health beliefs and practices when they are different from our own. It entails challenging our own assumptions, asking the right questions, and working with the individual and the community in a manner that respects their lifestyle and approach to maintaining health and treating illness. Multicultural health integrates different approaches to care and incorporates the culture and belief system of the health care recipient while providing care within the legal, ethical, and medically sound practices of the practitioner's medical system.

Knowing the health practices and cultures of all groups is not possible, but becoming familiar with different health beliefs and preferences can be beneficial and improve the effectiveness of health care services. In this text, generalizations about cultural groups are provided, but it is important to realize that many subcultures exist within those cultures, and people vary in the degree to which they identify with the beliefs and

practices of their culture of origin. Awareness of general differences can help health care professionals provide services within a cultural context, but it is important to distinguish between **stereotyping** (the mistaken assumption that everyone in a given culture is alike) and generalizations. Generalizations can serve as a starting point but do not preclude factoring in individual characteristics such as education, nationality, faith, and level of cultural adaptation. Stereotypes and assumptions can be problematic and lead to errors and ineffective care. Remember, every person is unique, but understanding the generalizations can be beneficial because it moves people in the direction of becoming culturally competent and achieving cultural humility.

Cultural competence refers to an individual's or an agency's ability to work effectively with people from diverse backgrounds. *Culture* refers to a group's integrated patterns of behavior, and *competency* is the capacity to function effectively. Cultural competence occurs on a continuum, and this text is geared toward helping you progress along the continuum. **Cultural humility** is the preferred terminology instead of cultural competence by some professionals. "Cultural humility is a complementary concept and practice to cultural competence. Rather than creating a set of guidelines for cohesive cultural interaction, cultural humility implores people to question their own cultural upbringing and acknowledge the biases and limitations it may have instilled in them" (Stewart, 2024, para. 9).

Specific terms related to multicultural health, such as *race* and *acculturation*, need to be clarified, and this chapter begins by defining some of these terms. Following that is a discussion of the demographic landscape of the U.S. population and how it is changing, types and degrees of cultural adaptation, and health disparities and their causes. The chapter concludes with information about legislation related to health care that is designed to protect minorities.

Multicultural Health Terminology and Concepts

Some of the terminology related to multicultural health can be confusing, because the differences can be subtle. This section clarifies the meaning of terms such as *culture*, *discrimination*, *race*, *ethnicity*, *ethnocentricity*, and *cultural relativism*.

Culture

There are countless definitions of *culture*. The short explanation is that **culture** is everything that makes us who we are. E.B. Tylor (1871/1924), who is considered the founder of cultural anthropology, provided the classical definition of culture: "Culture, or civilization, taken in its broad, ethnographic sense, is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (p. 1). Tylor's definition is still widely cited today. A more current definition of *culture* is: "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups" (U.S. Department of Health and Human Services, n.d.a, para. 1).

Dominant culture refers to the primary or predominant culture of a region and does not indicate superiority. People simultaneously belong to numerous subcultures because we can be students, mothers, and bowling enthusiasts at the same time.

Culture is learned, changes over time, and is passed on from generation to generation. It is a very complex system, and many subcultures exist within each culture. For example, universities, businesses, neighborhoods, age groups, the gay and lesbian community, athletic teams, and musicians are subcultures of the dominant American culture.

Race and Ethnicity

Race refers to a person's physical characteristics, but race is not a scientific construct. Race is a social construct that was developed to categorize people, and it was based on the notion that some races are superior to others. Many professionals in the fields of biology, sociology, and anthropology have determined that race is a social construct and not a biological one because not one characteristic, trait, or gene distinguishes all the members of one so-called race from all the members of another so-called race. "Race is an unscientific, societally constructed taxonomy that is based on an ideology that views some human population groups as inherently superior to others on the basis of external physical characteristics or geographic origin. The concept of race is socially meaningful but of limited biological significance. Racial or ethnic variations in health status result primarily from variations among races in exposure or vulnerability to behavioral, psychosocial, material, and environmental risk factors and resources." (Williams et al., 1994, p. 26). The American Medical Association (2020) recognizes race as a social construct—rather than a biological one, and states, "This practice of accepting race as a biological construct—known as racial essentialism—exacerbates health disparities and results in detrimental health outcomes for marginalized and minoritized communities" (para. 2).

Why is race important? Because society makes it important. Race shapes social, cultural, political, ideological, and legal functions in society. Race is an institutionalized concept that has had devastating consequences. **Racism** is the belief that some races are superior to others by nature. Discrimination occurs when people act on that belief and treat people differently as a result. Discrimination can occur because of beliefs related to factors such as race, sexual orientation, dialect, religion, age, or gender. Research suggests that discrimination impacts health primarily through three major pathways: psychosocial stress, access to health and social resources, and violence and bodily harm. These pathways are related. For example, denied access to jobs and housing is a cause of psychosocial stress. The ideology of race has been the root of suffering and death for centuries, even though it has no scientific merit.

Ethnicity is the socially defined characteristic of a group of people who share common cultural factors such as history, national origin, religious belief, or language. How is ethnicity different from race? Race is primarily based on physical characteristics, whereas ethnicity is based on social and cultural identities. Culture is based on experiences. One can belong to a culture without having ancestral roots to that culture. For example, people

can belong to the hip-hop culture, but they were not born into the culture. Let's consider another example. The physical characteristics of Caucasians (a race) are typically light skin and eyes, narrow noses, thin lips, and straight or wavy hair. A person whose appearance matches these characteristics is said to be Caucasian. However, there are many ethnicities within the Caucasian race such as Dutch, Irish, Greek, German, French, and so on. What differentiates these Caucasian groups ethnically from one another is their country of origin, language, cultural heritage and traditions, beliefs, and rituals.

The 2020 U.S. Census questions related to ethnicity and race can be found in **Figures 1.1** and **1.2**. **Box 1.1** explains how these race terms were defined in the 2020 Census. The U.S. government declared that Hispanic and Latino are an ethnicity and not a race.

Is this person of Hispanic, Latino, or Spanish origin?

☐ No, not of Hispanic, Latino, or Spanish origin

☐ Yes, Mexican, Mexican Am., Chicano

☐ Yes, Puerto Rican

☐ Yes, Cuban

☐ Yes, another Hispanic, Latino, or Spanish origin – *Print, for example, Salvadoran, Dominican, Colombian, Guatemalan, Spaniard, Ecuadorian, etc.* ↗

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Figure 1.1 U.S. Census origin question, 2020.

On March 28, 2024, the reporting standards for race and ethnicity were changed by the U.S. Office of Management and Budget. These standards are required for maintaining, collecting, and presenting race/ethnicity data across federal agencies. Among the biggest updates was the addition of a new “Middle Eastern and North African” reporting category. The updated standards also aim to provide balance across the race/ethnicity definitions and to remove any outdated and offensive terminology. The following are some of the updates that were made:

- The phrase “who maintains tribal affiliation or community attachment” was removed from the American Indian or Alaska Native (AIAN) definition.
- The phrase “(including Central America)” was changed to listing “Central America” co-equally with North America and South America in the AIAN definition.
- The term “Far East” was replaced with “Central or East Asia” and the term “Indian Subcontinent” was replaced with “South Asia” in the Asian definition.
- The term “Negro” was removed from the Black or African American definition.
- “Cuban” being listed twice in the Hispanic or Latino definition was corrected.

What is this person's race?
Mark ☒ one or more boxes **AND** print origins.

☐ White – *Print, for example, German, Irish, English, Italian, Lebanese, Egyptian, etc.* ↴

☐ Black or African Am. – *Print, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.* ↴

☐ American Indian or Alaska Native – *Print name of enrolled or principal tribe(s), for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.* ↴

☐ Chinese

☐ Vietnamese

☐ Native Hawaiian

☐ Filipino

☐ Korean

☐ Samoan

☐ Asian Indian☐ Japanese☐ Chamorro☐ Other Asian – *Print, for example, Pakistani, Cambodian, Hmong, etc.* ↴☐ Other Pacific Islander – *Print, for example, Tongan, Fijian, Marshallese, etc.* ↴
☐ Some other race – *Print race or origin.* ↴

Figure 1.2 U.S. Census race question, 2020.

BOX 1.1 Definition of Race Categories Used in the U.S. Census (2020)

White

The category “White” includes all individuals who identify with one or more nationalities or ethnic groups originating in Europe, the Middle East, or North Africa. Examples of these groups include, but are not limited to, German, Irish, English, Italian, Lebanese, Egyptian, Polish, French, Iranian, Slavic, Cajun, and Chaldean.

Black or African American

The category “Black or African American” includes all individuals who identify with one or more nationalities or ethnic groups originating in any of the Black racial groups of Africa. Examples of these groups include, but are not limited to, African American,

(Continued)

BOX 1.1 Definition of Race Categories Used in the U.S. Census (2020) (Continued)

Jamaican, Haitian, Nigerian, Ethiopian, and Somali. The category also includes groups such as Ghanaian, South African, Barbadian, Kenyan, Liberian, and Bahamian.

American Indian or Alaska Native

The category "American Indian or Alaska Native" includes all individuals who identify with any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. It includes people who identify as "American Indian" or "Alaska Native" and includes groups such as Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, and Nome Eskimo Community.

Asian

The category "Asian" includes all individuals who identify with one or more nationalities or ethnic groups originating in the Far East, Southeast Asia, or the Indian subcontinent. Examples of these groups include, but are not limited to, Chinese, Filipino, Asian Indian, Vietnamese, Korean, and Japanese. The category also includes groups such as Pakistani, Cambodian, Hmong, Thai, Bengali, Mien, and so on. There are individual Asian checkboxes for people who identify as one or more of the following:

- Chinese
- Filipino
- Asian Indian
- Vietnamese
- Korean
- Japanese
- Other Asian (e.g., Pakistani, Cambodian, and Hmong)

Native Hawaiian or Other Pacific Islander

The category "Native Hawaiian or Other Pacific Islander" includes all individuals who identify with one or more nationalities or ethnic groups originating in Hawaii, Guam, Samoa, or other Pacific Islands. Examples of these groups include, but are not limited to, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, and Marshallese. The category also includes groups such as Palauan, Tahitian, Chuukese, Pohnpeian, Saipanese, Yapese, and so on. There are individual Pacific Islander checkboxes for people who identify as one or more of the following:

- Native Hawaiian
- Samoan
- Chamorro
- Other Pacific Islander (e.g., Tongan, Fijian, and Marshallese)

Some Other Race

This category is defined by the Census respondent.

- The term “Other” was removed from the “Native Hawaiian and Other Pacific Islander” category name.
- The terminology “Multiracial and/or Multiethnic” rather than “Two or More Races” was used when presenting data for those who identify with multiple race/ethnicity minimum reporting categories.
- The terms “majority” and “minority” are no longer permissible in tabulations except when statistically accurate and used for statistical descriptions or when legal requirements call for use of the terms (Marks et al., 2024).

Table 1.1 (Marks et al., 2024) contains the revised race and ethnicity categories and descriptions being used by federal agencies.

TABLE 1.1 Revised Race and Ethnicity Definitions and Categories

Minimum Race/Ethnicity Reporting Category	Definition
American Indian or Alaska Native	Individuals with origins in any of the original peoples of North, Central, and South America, including, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, and Maya.
Asian	Individuals with origins in any of the original peoples of Central or East Asia, Southeast Asia, or South Asia, including, for example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, and Japanese.
Black or African American	Individuals with origins in any of the Black racial groups of Africa, including, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali.
Hispanic or Latino	Includes individuals of Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, and other Central or South American or Spanish culture or origin.
Middle Eastern or North African	Individuals with origins in any of the original peoples of the Middle East or North Africa, including, for example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, and Israeli.
Native Hawaiian or Pacific Islander	Individuals with origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands, including, for example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, and Marshallese.
White	Individuals with origins in any of the original peoples of Europe, including, for example, English, German, Irish, Italian, Polish, and Scottish.

Source: Rachel Marks, Nicholas Jones, and Karen Battle, “Revised Definitions for Minimum Race/Ethnicity Reporting Categories in 2024 SPD 15,” 2024.

How gender is recorded was changed in 2025. An executive order signed by President Trump in January 2025 states that federal agencies should only recognize two sexes, male and female. The executive order applies to federal agencies and their employees but may apply to others after the time of this writing (e.g., recipients of federal funding) as this language shift continues to take place. The executive order requires the use “sex” and not “gender.”

Ethnocentricity and Cultural Relativism

Ethnocentricity refers to people’s belief that their culture is superior to another one. This can cause problems in the health care field. If health care workers believe that their approach is the only way to prevent or treat a health problem, they may disrespect or ignore the patient’s cultural beliefs and values. The health care professional may not take into consideration that the listener may have different views than the provider. This can lead to ineffective communication and treatment and leave listeners feeling unimportant, frustrated, disrespected, or confused about how to prevent or treat the health issue, and they might view the professional as uneducated, uncooperative, unapproachable, or closed-minded.

To be effective, one needs to see and appreciate the value of different cultures; this is referred to as **cultural relativism**. The phrase developed in the field of anthropology to refute the idea of cultural ethnocentricity. It posits that all cultures are of equal value and need to be studied from a neutral point of view. It rejects value judgments on cultures and holds the belief that no culture is superior to any other. Cultural relativism takes an objective view of cultures and incorporates the idea that a society’s moral code defines whether something is right (or wrong) for members of that society.

WHAT DO YOU THINK?

Cultural imposition occurs when one cultural group, usually the majority group, forces their view on another culture or subculture. Can you provide examples of cultural imposition? Do you think it is ethical? Why or why not?

Cultural Adaptation

With the changing landscape in the United States, professionals are encouraged to consider the degree of **cultural adaptation** that the person has experienced. Cultural adaptation refers to the degree to which a person or community has adapted to the dominant culture or retained their traditional practices. Generally, first-generation people will identify more with their culture of origin than those from the third generation. Therefore, when working with a first-generation person, health care professionals need to be more sensitive to issues such as language barriers, distrust, lack of understanding of the American medical system, and ties to traditional beliefs.

Acculturation relates to the degree of adaptation that has taken place, a process whereby members of one cultural group adopt the beliefs and behaviors of another group. Essentially, members of the **minority** cultural group take up many of the dominant culture’s traits. Because of the great variety of peoples who have immigrated to the United States, the country is often said to be a melting pot. However, given the tendencies of cultural groups to locate together and maintain some familiar practices their land of origin, the country also has been described as a salad bowl. Both these analogies reflect the process of cultural interaction.

Except for the Indigenous population, everyone in the United States is descended from settlers, immigrants, and refugees. Each group of people who traveled to America built on the strengths of their own culture while adapting to a new social and economic environment through acculturation. Acculturation can include adopting customs from one culture to another or direct change of customs as one culture dominates the other. Some interactions between cultures generate discriminatory responses, individual stress, and family conflict, whereas others create an appreciation for variation as customs or practices are welcomed into other cultures. Whether melting or mixing, the interrelationship of cultures in the United States is constantly changing. The process continues as new people arrive in the country.

People can experience different levels of acculturation as illustrated in Berry’s (1997) acculturation framework (see **Figure 1.3**). The acculturation framework identifies four levels of integration:

- An **assimilated** individual demonstrates high-dominant and low-ethnic society immersion. This entails moving away from one’s ethnic society and immersing fully in the dominant society (Stephenson, 2000). As a result, the minority group disappears through the loss of particular identifying physical or sociocultural characteristics. This usually occurs when people immigrate to a new geographic region and in their desire to be part of the mainstream give up most of their culture traits of origin and take on a new cultural identity defined by the dominant culture. Many people do not fully assimilate, however, and tend to keep some of their original cultural beliefs.
- An integrated person has high-dominant and high-ethnic immersion. Integration entails immersion in both ethnic and dominant societies (Stephenson, 2000). An example of an integrated person is a Russian American who socializes with the dominant group but chooses to speak Russian at home and marries a person who is Russian.
- Separated individuals have low-dominant and high-ethnic immersion. A separated

Dominant immersion		Ethnic immersion
Assimilated	Integrated	
Marginal	Separated	

Figure 1.3 Berry’s acculturation framework.

individual withdraws from the dominant society and completely submerges into the ethnic society (Stephenson, 2000). An example is a person who lives in an ethnic community such as Little Italy or Chinatown.

- A marginalized individual has low-dominant and low-ethnic immersion and does not identify with any particular culture or belief system.

People who are marginalized tend to have the most psychological problems and the highest stress levels. These individuals often lack social support systems and are not accepted by the dominant society or their culture of origin. People in the separated mode are accepted in their ethnic society but may not be accepted by the dominant culture, leaving the person feeling alienated. The integrated and assimilated modes are considered the most psychologically healthy adaptation styles, although some individuals benefit more from one than from the other. Western Europeans and individuals whose families have been in the U.S. for a number of generations (and typically do not encounter discrimination) are most likely to adopt an assimilated mode because they have many beliefs and attributes of the dominant society. Individuals who retain value structures from their country of origin and encounter discrimination benefit more from an integrated (bicultural) mode. To be bicultural one must be knowledgeable about both cultures and see the positive attributes of both.

There are criticisms of Berry's model. For example, acculturation can be influenced by the level of similarity between one's own culture and the receiving society (e.g., language, etiquette). Determining what is a high or low level is arbitrary. Several other acculturation models have been developed by different disciplines after Berry's framework.

The degree to which people identify with their culture of origin is sometimes referred to as **heritage consistency**. Some indicators that can help professionals assess the level of cultural adaptation are inquiring about how long the person has been in the country, how often the person returns to their culture of origin, what holidays the person celebrates, what language the person speaks at home, and how much knowledge the person has of their culture of origin.

Are people who have higher levels of cultural adaptation healthier? Despite increasing research on the relationships between acculturation and health, the answer to that question is not clear as the results vary in terms of direction and magnitude. Research on the influence of acculturation on health indicates contradictory results because the variables are complex. The answer is also dependent on which health habits are incorporated into one's lifestyle and which are lost. For example, acculturation can have detrimental effects on one's dietary patterns if a person is from a culture in which eating fruits and vegetables is common and the person incorporates the habit of eating at fast-food restaurants, which is customary in the U.S. On the other hand, if someone moves from a culture in which smoking is common to a culture in which it is frowned upon, the person may stop smoking and reduce their chances of illness.

Fox et al. (2017) posit that sociocultural context can change the level of exposure to the host culture, which can impact internalization of host cultural orientation and alter

the extent to which acculturation causes stress and unhealthy behaviors. They focus on eight aspects of sociocultural context: “(1) neighborhood ethnocultural composition, (2) discrimination, (3) discrepancy between origin and host environments, (4) discrepancy between heritage and host cultures, (5) origin group, host group, and individual attitudes towards assimilation, (6) variation in targets of assimilation within host community, (7) public policy and resources, and (8) migration selection bias” (Fox et al., 2017, p. 119).

Diversity Within the United States

A great strength of the United States is the diversity of the people. Historically, waves of immigrants have come to the United States and brought their traditions, languages, and cultures with them, creating a country that developed a very diverse landscape. Some peoples, such as Native Americans, were already on the land, and others, such as African Americans, were forced to come to the United States. An unfortunate outcome was that despite its great advantages, this diversity contributed to racial and cultural clashes as well as imbalances in equality and opportunities that continue today. These positive and adverse consequences of diversity must be considered in our health care approaches, particularly because the demographics continue to change and the inequalities persist. The delivery of health care to individuals, families, and communities must meet the needs of the wide variety of people who reside in and visit the United States.

The percentage of the U.S. population characterized as White is decreasing (see **Table 1.2**; U.S. Census Bureau, 2011/2024). This is an important consideration for health care providers because ethnic minorities often experience poorer health status when compared to White Americans.

Health Disparities

Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities. Health disparities occur among groups who have persistently experienced historic trauma, social disadvantage, or discrimination.

Health disparities are widespread in the United States, as demonstrated by the fact that many minority groups have a higher incidence of chronic diseases, higher mortality, and poorer health outcomes when compared to White Americans. Numerous other disparities exist, such as the health of rural residents being poorer than urban residents and people with disabilities reporting worse health compared to those without disabilities.

Eliminating health disparities is an important goal for our nation and is one of the five overarching goals of **Healthy People 2030**:

- Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.

TABLE 1.2 Population Data Related to Origin and Race

	2000 (n = 281,421,906)	2010 (n = 308,745,538)	2023 estimates* (n = 334,914,896)
	Percentage of Total Population	Percentage of Total Population	Percent of Total Population
Hispanic Origin and Race			
Hispanic or Latino	12.5	16.3	19.4
White non-Hispanic	75.1	72.4	60.5
Black or African American	12.3	12.6	12.1
American Indian and Alaska Native	0.9	0.9	1.0
Asian	3.6	4.8	6.0
Native Hawaiian and Other Pacific Islander	0.1	0.2	0.2
Two or more races ¹	2.4	2.9	0.8

¹In the 2000 U.S. Census, an error in data processing resulted in an overstatement of the two or more races population by about 1 million people (about 15%) nationally, which almost entirely affected race combinations involving some other race. Therefore, data users should assess observed changes in the two or more races population and race combinations involving some other race between the 2000 Census and the 2010 Census with caution.

* U.S. Census Bureau. (2024, July 31).

- Create social, physical, and economic environments that promote attaining full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all (Office of Disease Prevention and Health Promotion, 2020).

Some examples of health disparities follow, but numerous statistics illuminate these differences as well:

- In the past 2 decades, suicide rates have been consistently higher in rural America than in urban America. Between 2000–2020, suicide rates increased 46% in non-metro areas compared to 27.3% in metro areas (Centers for Disease Control and Prevention [CDC], 2024).
- Of the race and Hispanic origin groups in 2023, poverty rates were highest for AIAN (21.2%) and Black individuals (17.9%). The poverty rate was lowest for non-Hispanic White individuals (7.7%; Shrider, 2024).

- Black (10.9 per 1,000) and AIAN (9.1 per 1,000) infants were at least two times as likely to die as White infants (4.5 per 1,000) as of 2022. Black and AIAN women also had the highest rates of pregnancy-related mortality (Ndugga et al., 2024).
- In 2021, 13.6% of AIAN adults were diagnosed with diabetes compared to 6.9% of adult non-Hispanic White adults (American Diabetes Association, n.d.).
- A substantially smaller share of LGBT+ women aged 40–64 report having had a mammogram in the past 2 years than non-LGBT+ women (35% versus 64%; Dawson et al., 2021).
- All racial and ethnic groups experienced substantial loss of life expectancy during the COVID-19 public health emergency. Between 2019 and 2021, non-Hispanic AIAN communities suffered the greatest loss in life expectancy (~6.6 years, a 9.2% decline), followed by Hispanic (~4.2 years, 5.1% decline), Non-Hispanic Black (~4 years, 5.3% decline), non-Hispanic White (~2.4 years, 3.0% decline), and non-Hispanic Asian (~2.1 years, 2.5% decline; Agency for Healthcare Research and Quality, 2021).
- Hispanic and AIAN populations are less likely to have health insurance coverage compared with other racial and ethnic groups (Agency for Healthcare Research and Quality, 2021).

DID YOU KNOW?

April is National Minority Health month. The purpose is to raise awareness of health disparities. Public health agencies across the nation engage in activities to raise awareness about the health disparities that exist around issues such as alcohol and drug addiction and infectious diseases.

Causes of Health Disparities

Health disparities are often driven by social, economic, and environmental factors that are beyond the control of individuals. These factors are often referred to as social determinants of health (SDOH; **Figure 1.4**). The authors prefer to use the term *social drivers* as some of these factors can be overcome, such as poverty and education, and the word *determinant* refers to a factor that decisively affects the nature or outcome of something. There are also factors within the person's control that impact health as well (e.g., using tanning booths).

Most experts agree that the causes of health disparities are multiple and complex; no single factor explains why they exist across such a wide range of health measures, yet some have more influence than others. Socioeconomic status (SES) is one of the most important predictors of health. SES is typically measured by educational attainment,



Figure 1.4 Social determinants of health.

income, wealth, occupation, or a combination of these factors. In general, the higher one's SES, the better one's health. Socioeconomic factors affect one's ability to afford healthy foods, medical care, a gym membership, education, and housing, for example. SES also affects where you live, which impacts air quality, stress, safety, and so on.

Another way to frame the causes of health disparities is via the factors affecting health that were identified in the 1974 Lalonde report, "A New Perspective on the Health of Canadians." This report probably was the first acknowledgment by a major industrialized country that health is determined by more than biological factors. The report led to the development of the "health field" concept, which identified four health fields that are interdependently responsible for individual health:

- *Environment.* All matters related to health external to the human body and over which the individual has little or no control. Includes the physical and social environment.
- *Human biology.* All aspects of health, physical and mental, developed within the human body as a result of organic makeup.
- *Lifestyle.* The aggregation of personal decisions over which the individual has control. Self-imposed risks created by unhealthy lifestyle choices can be said to contribute to, or cause, illness or death.
- *Health care organization.* The quantity, quality, arrangement, nature, and relationships of people and resources in the provision of health care.

These four domains were later refined to include five intersecting domains:

- Environmental exposures
- Genetics

- Behavior (lifestyle) choices
- Social circumstances
- Medical care (Institute of Medicine [IOM], 2001)

All five domains are integrated and affected by one another. For example, people who have more education usually have higher incomes (social circumstances), are more likely to live in neighborhoods with fewer environmental health risks (environmental exposures), and have money to purchase healthier foods (lifestyle). Let's look at each of these domains in more detail.

Environmental Exposures

Environmental conditions are believed to play an important role in producing and maintaining health disparities. The environment influences our health in many ways, including through exposures to physical, chemical, and biological risk factors and through related changes in our behavior in response to those factors. In general, White and minority populations do not have the same exposure to environmental health threats because they live in different neighborhoods. Residential segregation still exists. The 2019 American Community Survey data found that 23.6% of metropolitan areas were more segregated than in 2010 (Menendian et al., 2021). **Figure 1.5** shows the diversity index for each state.

“The effects of residential segregation are often stark: Black and Hispanic Americans who live in highly segregated and isolated neighborhoods have lower housing quality, higher concentrations of poverty, and less access to good jobs and education. As a consequence,

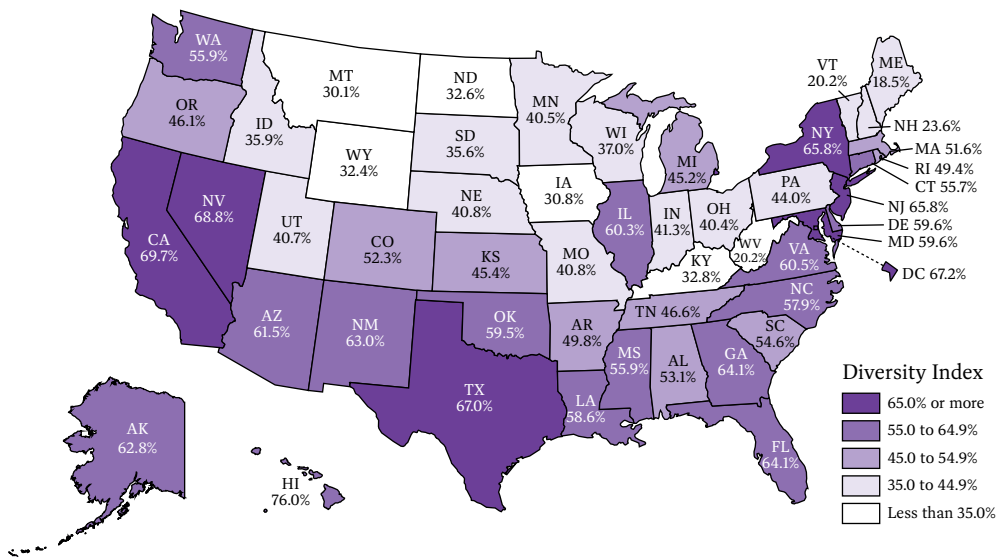


Figure 1.5 Racial and ethnic diversity index by state, 2020. The diversity index tells us the chance that two people chosen at random will be from different racial and ethnic groups.

they experience greater stress and have a higher risk of illness and death” (Schwartz, 2018, para. 4). People of color are disproportionately concentrated in areas with high poverty and crime rates, where essential resources such as quality schools, full-service grocery stores, safe and healthy parks, and reliable transportation are often lacking (Turner & Greene, n.d.).

Minorities tend to live in poorer areas, and these disadvantaged neighborhoods are exposed to greater health hazards, including tobacco and alcohol advertisements, toxic waste incinerators, and air pollution. It has been known for a long time that Black and Hispanic Americans tend to live in areas with more pollution compared to where White Americans live. Economic stress within a community may exacerbate tensions between social groups, magnify stressors, and induce maladaptive coping behaviors such as smoking and alcohol use, all of which make individuals more vulnerable to illness (e.g., depression, high blood pressure). Factors associated with living in poor neighborhoods—crime, noise, traffic, litter, crowding, and physical deterioration—can also cause stress.

Genetics

Genetics have been linked to many diseases, including diabetes, cancer, sickle-cell anemia, cystic fibrosis, hemophilia, Tay-Sachs disease, schizophrenia, and Down syndrome. There are more than 7,000 rare genetic diseases, of which about three quarters affect children (Murdock Children’s Research Institute, n.d.). Some genetic diseases are a result of a single mutated gene, and other disorders are complex, multifactorial, or polygenic mutations. (*Multifactorial* means that the disease or disorder is likely to be associated with the effects of multiple genes in combination with lifestyle and environmental factors.) Examples of multifactorial disorders are cancer, heart disease, and diabetes. Although numerous studies have linked genetics to health, social and cultural factors play a role as well.

There are concerns about relating genetics and health disparities among races, because race is not truly biologically determined. Racial categories do not capture biological distinctiveness. Another problem with linking genetics to race is that many people have a mixed gene pool due to interracial marriages and partnerships. Also, it is difficult at times to determine which diseases are related to genetics and which are related to other factors.

While a few conditions have well-known ancestry-linked patterns—such as sickle cell trait being more common in people with ancestry from parts of Africa, the Mediterranean, or India—these patterns follow geographic ancestry and historical environments, not racial categories as used in everyday life or on the census. How genetics also play a role is related to physical characteristics as well, such as people with lighter skin tones being more susceptible to skin cancer. While certain genetic conditions may be more prevalent in specific racial groups, it is essential to approach this topic with an understanding of the broader context of health disparities and the limitations of using race as a biological determinant.

Genetic ancestry still matters in medicine, but it needs to be disentangled from race and interpreted within context. Studying genetic variants can help explain individual

differences in drug metabolism or disease susceptibility, and gene–environment interactions can clarify how certain genetic traits interact with pollution, diet, or stress to influence health. However, overemphasizing genetics in explaining racial health gaps risks obscuring the larger impact of racism and social inequity and may unintentionally reinforce stereotypes. A more accurate approach treats race as a social construct that shapes exposure to risks and resources, uses ancestry and specific genetic tests when biologically relevant, and focuses policy and practice on changing the social conditions that drive unequal health outcomes across racial lines.

Lifestyle

Lifestyle choices profoundly impact health, with factors like diet, exercise, sleep, stress, and substance use determining the risk for diseases and affecting mental well-being, quality of life, and longevity; positive choices like balanced nutrition and regular activity can prevent much disease, while poor habits like smoking and inactivity accelerate health decline, even in mid-life.

Health-related lifestyles—such as what people eat, how they move, sleep, use substances, and seek care—are deeply shaped by culture. Culture influences what is considered “normal,” acceptable, or desirable in daily routines, family roles, body size, and emotional expression, and these norms guide health behaviors from childhood onward. For example, shared beliefs about appropriate foods, meal patterns, and hospitality affect diet; expectations about gender and age shape who exercises, when, and where; and religious or spiritual teachings influence views on alcohol, tobacco, sexuality, and end-of-life decisions. Because these cultural patterns are learned and reinforced in families, peer groups, media, and faith communities, they can either support health-promoting lifestyles—such as strong social support and plant-based diets—or contribute to risk, such as heavy drinking in social events or norms against discussing mental health.

Social Circumstances

Social circumstances include factors such as SES, education level, stress, discrimination, marriage and partnerships, and family roles. SES is made up of a combination of variables, including occupation, education, income, wealth, place of residence, and poverty. These variables do not have a direct effect on health, but they do have an indirect effect. For example, low SES does not cause disease, but poor nutrition due to the cost of healthy food, limited access to health care, and substandard housing certainly do, and these are just a few of the many indirect effects. Discrimination also does not cause poor health directly, but it can lead to depression and high blood pressure.

One variable of social circumstances, poverty, can be measured in many ways. One approach is to measure the number of people who are recipients of federal aid programs, such as food stamps, public housing, and Head Start. Another method is through labor statistics, but the most common way is through the federal government’s measure of poverty based

on income. The federal government's definition of poverty is based on a threshold defined by income, and it is updated annually. So, how is poverty related to race and ethnicity?

Poverty is higher among certain racial and ethnic groups. In 2023 the highest poverty rate by race is found among American Indians (21.2%), with Black Americans (17.9%) having the second highest, and Hispanic Americans (of any race) having the third highest (16.6%; Statista, 2024). Poverty is a contributing factor to poor health, because it affects many factors, including where people live and their access to health care. Poverty also impacts access to health aids. Adopting many healthy behaviors does not require money yet having more money to pay for tobacco cessation aids, sunscreen, fitness club memberships, and Waterpiks can help people achieve better health.

Social circumstances are related to culture in several ways e.g., cultural norms related to prioritizing education. Some cultures prioritize education while others do not. Support in the home and the community have cultural ties and a lack of support can lead to health problems and negative behaviors. Strong cultural identity and community cohesion can provide social support, a sense of meaning, and collective resources that buffer stress and improve both physical and mental health, showing that culture and social circumstances together can either undermine or promote health across the life course.

Medical Care

The shortfalls for minorities in the health care system in the United States can be categorized into two general areas: (a) lack of access to care, (b) lower quality of care.

Lack of Access to Medical Care

Research has shown that without access to timely and effective preventive care, people may be at risk for potentially avoidable conditions, such as asthma, diabetes, and immunizable conditions. Access to health care is also important for prompt treatment and follow-up to illness and injury.

Access to health care is a problem for many Americans due to lack of health care insurance. In 2021, 8.6% of people in the United States did not have health insurance (U.S. Census Bureau, 2022). In that same year, 5.7% of White Americans alone, 5.8% of Asian Americans alone, 7.5% for multiracial, 9.6% of Black or African Americans alone, 10.1% of Native Hawaiians and Other Pacific Islanders alone, 10.6% for some other race alone, 17.7% of Hispanic or Latino Americans, and 18.8% of AIAN alone were uninsured (U.S. Census Bureau, 2022).

Lower Quality of Care

Despite improvements, differences persist in health care quality among racial and ethnic minority groups. People in low-income families also experience poorer quality care. Disparities in quality of care are common. The Agency for Healthcare Research and Quality's (2021) *National Healthcare Quality and Disparities Report* is based on more than 250 measures of quality and disparities covering a broad array of health care services

and settings. Here are a few examples from the report that show the number of quality measures for which each racial or ethnic group experienced worse quality care compared with White Americans:

- Black Americans received worse care than White Americans for 43% of quality measures.
- AIAN received worse care than White Americans for 40% of quality measures.
- Hispanic Americans received worse care than non-Hispanic White Americans for 36% of quality measures.
- Asian, Native Hawaiian, and Pacific Islander Americans received worse care than White Americans for about 30% of quality measures, but Asian Americans also received better care for about 30% of quality measures (Agency for Healthcare Research and Quality, 2021).

Legal Protections for Minorities

Many laws have been passed to help reduce discrimination, including in the health care arena. The Civil Rights Act of 1964 was passed by Congress and signed into law by President Lyndon Baines Johnson. Title VI of the Civil Rights Act prohibits federally funded programs or activities from discriminating on the basis of race, color, or national origin. In areas involving discrimination in health care, the Office for Civil Rights (OCR) of the Department of Health and Human Services (HHS), is responsible for enforcement. Title VI of the act is the operative section that informs nondiscrimination in health care. It has three key elements:

- It established a national priority against discrimination in the use of federal funds.
- It authorized federal agencies to establish standards of nondiscrimination.
- It provided for enforcement by withholding funds or by any other means authorized by law.

Since the Civil Rights Act of 1964 was passed, numerous other statutes and regulations have been created to address discrimination against ethnic minorities in health care, including the **Hill–Burton Act**. The Hill–Burton Act has been amended a number of times since its inception. The amendment entitled “Community Service Assurance Under Title IV of the U.S. Public Health Service Act” requires facilities to provide services to persons living within the service area without discrimination based on race, national origin, color, creed, or any other reason not related to the person’s need for services. The subsequent HHS regulations set forth the requirements with which a Hill–Burton facility must comply (HHS, OCR, 2015):

- Provide emergency services to any person living in its service area who cannot afford those services