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Health Disparities and Health-Seeking Behavior Among Latino Men: A Review of the Literature

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Many studies examining Latino health-seeking behavior have focused on comparing Latinos with other ethnic groups, primarily with Whites and African Americans. However, without the benefit of intragroup or intracultural comparisons, such studies fail to identify the subtle variation in health-seeking strategies and the range of needs within the Latino ethnic group, and thus are compromised in their capacity to guide and improve practice and policy. This article reviews the literature regarding health-seeking behavior and Latino men. Important factors identified include gender, occupation, and responsiveness of the health care system along with characteristics of the individual.

Keywords: *health-seeking behavior; health disparities; Hispanics*

This is an extensive review of the literature that demonstrates that few studies have been conducted evaluating and comparing the many subgroups of Latino culture. This review reports generalized biological, socioeconomic, and psychological variables concerning health-seeking behavior among Latinos and is therefore limited by the shortcoming of intracultural studies.

According to the Department of Health and Human Services, there continue to be disparities in the incidence of illness and death experienced by African American, American Indian, Alaska Native, Pacific Islander, and Hispanic populations when compared to the total U.S. population, in spite of the progress being made in the overall health of the nation. These disparities are across a wide range of illnesses (Hamburg, 1998; Smedley, Stith, & Nelson, 2003). In their

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National Survey of American Families, Staveteig and Wigton (2000) confirmed that disparities exist both within and across racial and ethnic groups; even across groups at higher income levels, Whites and Asians consistently fare better than African Americans, Native Americans, and Latinos.

Explanations for these ethnic and racial health disparities are various and complex. They have been attributed to differences in genetics (Evans, Barer, & Marmor, 1994), social position (Dressler, 1988a,b, 1993, 1994ab; Dressler & Bindon, 1997; Dressler, Santos, Gallagher, & Viteri, 1987), income (Quinn, 2000), exposure to unhealthy and toxic environments (U.S. Department of Health and Human Services, 2000a), health literacy (Kellogg, 2003), language (Mueller, Ortega, Parker, Patil, & Askenazi, 1999; Nicholas, 2000; Timmins, 2002), access to health services (Andrulis, 1998; Berk & Schur, 2001; Brown, Wyn, & Teleki, 2000; Mueller et al., 1999; Shedlin & Shulman, 2004), and the interaction between and among these variables.

DISPARITIES IN HEALTH SERVICE ACCESS

Linked to ethnic and racial disparities in morbidity and mortality are ethnic and racial disparities in access to health services. Although some studies suggest that ethnic and racial disparities in health outcomes are directly related to disparities in access to health services (Carlisle & Leake, 1997; Murray, 2003; Staveteig & Wigton, 2000; Willis, 2002), the connection between health disparities and disparities in access to health services is not always clear and predictable, and may be mitigated by many other factors. For example, although the Institute of Medicine associated health disparities with inequalities in access and a pluralistic health care system, its report from the Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care admitted that the issue was not limited to one disease, but rather was "remarkably consistent across a range of illnesses and health care services" (Smedley et al., 2003, p. 5). The report suggested that the relationship between health and health care access might be more indirect, mitigated by common variables. Similarly, Bolen, Rhodes, Powell-Griner, Bland, and Holtzman (2000) demonstrated that differences in the distribution of health care

access, health-status indicators, and health-risk behaviors, and the use of clinical services across racial and ethnic groups, all could be attributed to socioeconomic factors. Drevdahl (1999) combined the concepts of access to health care and socioeconomic status and found that being poor was a major deterrent to obtaining equitable health care. Yet Drevdahl also found that when ethnic minority populations did have equal access to health care, they still had poorer health.

Most explanations for ethnic disparities in access fall into two categories: one focuses on the characteristics of the seeker of health care (ethnicity, language, income, citizenship status, sex, education, and health needs and status); and the other focuses on the health care system (institutionalized racism, ethnocentrism, cultural competence, location, bureaucratic barriers, and services provided, among others). Both explanations are relevant to the Hispanic population, and there is a considerable body of research suggesting that being Hispanic is associated with liabilities involving both the characteristics of the seeker and the responsiveness of the health care system.

CHARACTERISTICS OF HEALTH SEEKERS

Ethnicity

Latinos, representing 12.5% of the U.S. population (U.S. Bureau of the Census, 2004), are especially vulnerable to both health disparities and disparities in access to health care. As a group, they suffer higher mortality rates from biliary disease, type II diabetes, diabetic nephropathy, end-stage renal disease, gastric cancer, liver disease, homicide, and HIV than do non-Hispanic groups (HIV/AIDS Among Hispanics/Latinos in the United States, 2007; Lawrence & Tuley, 1996; Smedley et al., 2003). Latinos, along with American Indians and Alaska Natives, were reported to have higher rates of hypertension, obesity, and diabetes, even when clinical conditions were the same (Smedley et al., 2003).

Summarizing the findings from the state-specific Behavioral Health Risk Factor Surveillance System, Bolen et al. (2000) reported differences in access to and use of clinical services across five racial and ethnic groups. In Arizona, Latinos were reported to have the highest median risk factor prevalence rates of the groups studied in terms of cost as a barrier to health care, had the second highest prevalence rate of no health insurance (Bolen et al., 2000), and were least likely to have had routine physical examinations. Carlisle and Leake (1997) found racial and ethnic disparities in access to cardiac procedures in which Latinos, along with African Americans, were less likely to undergo coronary artery angiographies, bypass surgery, or angioplasties across all insurance categories.

In 2000, of the 41.2 million people in the United States without health care insurance, nearly one third were Hispanic, which is three times the rate of non-Hispanic Whites (Health Insurance Coverage, 2001), despite the fact they made up less

than 13% of the general population. Hispanic families have a higher proportion than non-Hispanics of primary wage earners making less than \$7.00 per hour or only \$14,560 annually, which results in Latinos being unable to afford family health insurance premiums of approximately \$6,000 per year if not fully supplemented by employer-based contributions (Harrell & Carrasquillo, 2003). Paradoxically, an income of \$14,560 places Latinos above the cutoff rates to obtain publicly funded insurance.

Immigrant Status

For undocumented immigrants, the situation is worse (Harrell & Carrasquillo, 2003). According to Quinn's 2000 study, only about 25% of the approximately 3.5 million undocumented Latinos in the United States had employer-based health insurance, with the other 75% having no insurance. Because publicly funded insurance programs require proof of legal residency, non-citizens without documentation are not eligible. Undocumented workers are at higher risk of exploitation than legal residents, especially in domestic service (agriculture) and manufacturing, where jobs frequently do not provide health benefits (Berk & Schur, 2001; Shurr & Feldmen, 2002). Even legally documented Latinos hesitate to enroll in public insurance programs to avoid calling attention to themselves, and those who have immigrated since 1996 are excluded from enrollment in public insurance for 5 years as a result of welfare reform (Quinn, 2000).

Occupation

Further compromising Hispanic health is the fact that undocumented workers often must take jobs in which there is the greatest exposure to unhealthy environments. Exposure to toxic substances in the air, water, soil, and food, as well as exposure to physical hazards, is a major contributor to illness, disability, and death among this population. Environmental hazards have been linked to race and socioeconomic status (U.S. Department of Health and Human Services, 2000a), with Hispanic agricultural workers having the highest rates of exposure to pollutants when compared to Anglos and African Americans (U.S. Department of Health and Human Services, 2000a).

The workplace environment has influenced health disparities in several ways. For example, in 1999, 32.2 million people (12% of the total U.S. population) were at or below poverty level, and 6.8% of these people were classified as working poor (Murray, 2003). The rate of working poor was 4.3% for Anglo males, 10.2% for the African-American population, and 10.7% for Latinos (Murray, 2003). According to Murray, African Americans and Latinos "lag behind White workers in desirability and prestige and compensation for their work" (2003, p. 222). Often these workers were found to receive few, if any, benefits, such as sick leave, health care coverage, or vacation (Fiscella & Franks, 1997; Grey, 1999).

Of concern for researchers examining the work environment is the occupational risk for injury and illness (Donham, 1990; Donham, Leistikow, Merchant, & Leonard, 1990; Donham, Rubino, & Thedell, 1977; Fink, 1998; Grey, 1999; Johnson, Dalmas, Noss, & Matanoski, 1995). Murray (2003) reported that research on occupational disease and injury has been inhibited by the widely held belief that the discovery of health hazards and the proposed remedies are cost prohibitive, thus negatively affecting the bottom line of business. There is also a lack of reliable data concerning the ethnic or racial makeup of those injured on the job (Murray, 2003). It is known that African Americans have a 37% greater chance of injury and 24% greater chance of death compared to Anglos, yet data concerning other minorities are missing (Murray, 2003).

The occupation of many undocumented Hispanic men increases the risk of poor health and limited access. For example, the majority of workers in U.S. meatpacking plants are recent immigrants, who either currently work in the industry or began their U.S. work experience in the industry. In addition to the danger of injury and illness, meatpackers are exposed to a variety of other conditions that can have a negative impact on health. These include cold, heat, noise, and stress (Campbell, 1999; Hedges, Hawkins, & Loeb, 1996).

According to the U.S. Bureau of the Census (2004), the number of individuals working in the meatpacking industry has increased from 359,000 in 1980 to 427,000 in 1997 (the last year reported). The average wage for these individuals has grown from \$6.99/hr in 1980 to \$9.98/hr in beef/hog processing and \$8.43 in poultry processing (U.S. Bureau of the Census, 2004). Often meatpackers must purchase their own protective gear from their employers. Both the American Federation of Labor and Congress of Industrial Organizations and the United Food and Commercial Workers International Union (UFCW) have sued the Bush administration on the issue of employer payment for personal protective equipment for employees. The U.S. Secretary of Labor filed papers with the court committing to issue a final rule in November 2007 (UFCW, 2007). The equipment is frequently bulky and heavy, which may ironically increase the possibility of injury.

Where benefits for many meatpackers include employer-based health insurance, which usually does not take effect until 6 months after initial employment (Hedges et al., 1996), the turnover period for jobs in many plants is often less than 6 months, and injuries most often occur during the first 6 months of employment (Grey, 1997, 1999; Hedges et al., 1996). In addition, if an injury occurs, there is no compensation for lost wages. Even with insurance, meatpackers frequently cannot afford to pay the 20% deductible to cover treatment for illnesses or injuries or functioning that occur when they are not working (Grey, 1997, 1999; Hedges et al., 1996).

For the Hispanic worker, wages in the meatpacking industry are higher than for similar jobs in Mexico or Central America, making it is worth the risk of illegal immigration to

work in the industry. Quinn (2000) reported approximately 3.5 million undocumented Hispanic workers in the United States, with the exact number in the meatpacking industry unknown. The industry perpetuates the recruitment of undocumented workers in areas near the U.S.–Mexican border, such as McAllen and Eagle Pass, Texas, using Spanish-language advertisements. According to a 1996 article by Hedges, Hawkins and Loeb in *U.S. News & World Report*, the industry “likes it when people are illegal, they work harder. . . because they never know when they (the INS) are coming.”

Migrant or immigrant workers who are recruited by the meatpacking industry frequently come to areas that are unprepared for their arrival. These communities often have had little exposure to cultures other than their own. Because of language differences and cultural misunderstandings, additional stress is placed on recent immigrants while they are adjusting to their new environments (Grey, 1999). Although it may be argued that these areas now benefit from being transnational, it is not an easy transition for either the new immigrants or the long-time residents.

Gender

Finally, the literature suggests Hispanic men in particular, are at risk for disparities in access to health care. It has been well documented that men of color in the United States have poorer health outcomes and less access to health care than do non-Hispanic White males (Addis & Mahalik, 2003; Nicholas, 2000; Rich & Ro, 2002; Ro, Casares, Treadwell, & Thomas, 2004). For example, oral health is an indicator of one’s overall general health, and men of color receive less dental care than Anglo men. Even with the ability to pay for such services, Hispanic men along with African American men have higher rates of untreated dental problems than do poor Anglo males. “Lack of access for dental care contributes to poor physical appearance, pain and discomfort, periodontal disease, and even delayed diagnosis of oral cancers, from which men of color die at a higher than expected rate” (National Cancer Institute, 2001; Rich & Ro, 2002; U.S. Department of Health and Human Services, 2000b). In addition, a higher proportion of men of color have no insurance coverage, are less likely to seek health care, and are less likely to receive adequate care when they do access health services compared to White males (Rich & Ro, 2002; Smedley et al., 2003).

Compounding low income and lack of health insurance with migrant (possibly undocumented) status, male gender, and high-risk working conditions considerations, rural Hispanic workers appear to have the highest liability for continued disparities in access to health care (Kellogg, 2003; Rich & Ro, 2002; Ro et al., 2004; Smith, 2003). For example, in the State of Iowa, Hispanic males have a higher rate of alcohol use than other state populations and experience more barriers to health care, such as difficulty obtaining transportation and a lack of health care providers who speak Spanish (IDPH, 2001; Yehieli et al., 2001) than any other population.

Research has demonstrated that men tend to seek access to health care providers less often than women (Kellogg, 2003; Rich & Ro, 2002). This tendency has resulted in poorer health outcomes for men (Addis & Mahalik, 2003; Galdas, Cheater, & Marshall, 2005; Kellogg, 2003; Nicholas, 2000; Plowden, 2003; Rich & Ro, 2002; Timmins, 2002).

Nicholas (2000) studied men's health in relation to cancer and determined that male role socialization was a strong indicator of when men sought health-related assistance. He hypothesized that male role socialization, which views men as less vulnerable to disease than women, was directly related to participants being less knowledgeable about health in general and about cancer in particular. In addition, Nicholas suggested that this lack of knowledge might contribute to men having poorer coping mechanisms to manage cancer than do women. Men may repress emotions, not report symptoms and treatment side effects, not ask for help, or not seek out help in general because they do not want to be seen as "unmanly" (Nicholas, 2000). Even when considering other factors that are reported to contribute to health care disparities, such as low socioeconomic status and lack of health insurance coverage, it is important to take into account how men view their own health needs in relation to their concepts of masculinity (Plowden, 2003; Rich & Ro, 2002; Ro et al., 2004).

RESPONSIVENESS OF HEALTH CARE SYSTEM

According to Rich and Ro (2002), one factor in the issue of health disparities and men of color is institutional racism. Their study maintained that providers do, whether consciously or unconsciously, consider race when determining treatment options and that institutions foster racism through their hiring practices, community relations, and clinical systems that, ironically, are intended to help people (Rich & Ro, 2002). Although providers strive to give appropriate and complete care to men of color, if they do not have staff who can serve as interpreters of language, culture, and religious practices, there will be barriers to care. Providers will be less likely to be aware of particular cultural or religious practices, which may decrease the value of the practitioner's advice and care (Rich & Ro, 2002). Such institutional shortcomings may reinforce feelings of inferiority in the ethnic health seeker.

Medical pluralism is less subtle in some situations. Large medical centers, for example, often are characterized by two systems of health care: one for individuals with insurance, who more often see staff attending physicians in private offices, and the other for those without insurance, whose care tends to be provided and directed by medical trainees (Rich & Ro, 2002). Such medical pluralism is replete with ethno-centric administrative and bureaucratic barriers to care (Smedley et al., 2003). This view is supported by White-Means (2000), who examined older individuals' patterns of health service access by race and found that race matters in the use of community services. Persistent racial differences were found to be

a function of "unmeasured" racism, meaning institutional and unrecognized racial prejudice or discrimination. White-Means concluded that "public policy that focuses solely on health finance may not remedy the existing racial disparities in health levels, a key factor affecting both the cost of health care and the overall quality of life in our nation" (2000 p. 88).

HEALTH-SEEKING BEHAVIOR

Several authors have examined the issue of health-seeking behavior of Latinos and the factors contributing to it. They have found, in general, Latinos seek out a variety of health care providers and methods to help themselves (Engebretson, 1994; Keegan, 1996; Martaus, 1986). Latinos use clinics and hospitals for scientific or allopathic care, care that focuses on illness and pathology, the dominant health care system in the United States (Sobralke, 2004). According to Sobralke (2004) allopathic care is not considered holistic; it is focused only on the body systems and typically does not include the mind and spirit. Molina, Zambrana, and Aguirre-Molina (1994) contend that while allopathy care reflects the dominant Anglo culture, it does not always fit the needs or other values of the Hispanic culture or any other culture in general (Dreher & MacNaughton, 2002). According to Congress (1992), traditional Mexican Americans view health from a holistic standpoint where one cannot separate physical problems from nonphysical problems.

Several studies have shown that Latinos use a combination of remedies for ailments; these include folk medicine, over-the-counter medications, herbal medicines, and traditional allopathic care to relieve or alleviate symptoms (Applewhite, 1995; Burk, Wiesner, & Keegan, 1995; Engebretson, 1994; Keegan, 1996; Skaer, Robinson, Sclar, & Harding, 1996). Use of either allopathic medicine or a traditional folk healer/curandero is dependent on a variety of factors such as the availability of the practitioner, the cost associated with the use, transportation, and the ability to take off from work (Larkey, Hecht, Miller, & Alatorre, 2001; Sobralke, 2004).

Early studies explored the use of health services and the definition of Hispanic concepts such as familism. These studies were focused on Mexican Americans living in neighborhood "barrios" of large urban centers or in communities of the American southwest (Hoppe & Heiler, 1975; Kay, 1977). Building on early work by Clark (1959), that identified the significance of family as a core theme in Hispanic culture, her work was further expanded on by Burk, Weiser, and Keegan (1995) who defined it as "the value of family as an interdependent and cooperative network of individuals" (p. 41). According to these and subsequent scholars, they found that familism is deeply rooted in the Mexican American culture and does not seem to change as people adapt to the American culture. For example, Ramos-Sanchez (2000) found that familism influences individuals behaviors when seeking mental health services. In 1989, McKenna found that "elders rely heavily on their families for their health needs" (p. 207). This

was further supported by Schiavenato (1997) who found in her study that families are very influential in assisting elders to make decisions about seeking and using health services in their communities, additionally she found that elders were influential with younger people. Thus the issue of familism is vital to the understanding of health-seeking behavior of Latinos. However, this is not the only issue that influences Latinos health-seeking behavior.

Keefe (1982) found in a study of foreign born and U.S. born Latinas suffering from mental illness that their health-seeking behavior correlated with several traits. These traits included (a) socioeconomic status, (b) level of acculturation, (c) intensity of religious affiliation, (d) presence of an extensive social support system, and (e) familiarity with public mental health services (p. 1472). This study showed that foreign born Mexican American women were poorer, thus limiting their ability to access mental health care. They were less sophisticated with American culture and lacked English language skills that limited their knowledge of the public resources and ability to communicate. Additionally, foreign born Latinas had a more limited social network for support during emotionally difficult times, thus relying on family. Further demonstrating the strength of the family was the finding that U.S. born Latinas, who have larger social networks, rather than using friends, would seek out family for emotional support.

In 1986, Martaus did a study of Mexican and Mexican American migrant farm workers in northwest Ohio in which categories of illness were uncovered. The study involved 20 workers of both genders, all of whom were more than 18 years old, had incomes less than \$8,000 annually, 16 were married and 5 had completed high school. Martaus found that these workers recognized illness by perceiving a change in normal physical functions or an inability to perform expected roles in the family, the community, or at work. Three categories of illness explanation were uncovered: hot/cold imbalances, illness of emotion, and illness caused by bacteria, viruses, or other microscopic organisms. Illness was evaluated according to severity, those that were of short duration, had a known cause or were easily treatable were defined as not serious. If an illness had a long duration, would not respond to home remedies or interfered with breathing or eating; it was defined as serious. Martaus found that study participants use a combination of methods to treat themselves and family members. These ranged from prayers to God or a favorite patron saint to home remedies to over the counter medications or to seeking out professional help. However, use of professional help was the least used method of treatment.

In 1996, Adams-McDarty did a study asking participants to describe health and illness and the actions they took to promote health and treat illness. The study involved 14 individuals in Mexico ranging from 19 to 85 years old. Although this study was conducted in Mexico, it is illustrative of the perceptions of many Mexican Americans. Health, according to

the participants, was described as (a) to be active, (b) free from illness, (c) to be happy and content, (d) to be physically fit, (e) able to work, (f) able to reach objects, (g) free from stress, and (h) have good color. Conversely, illness was described as (a) body not functioning correctly, (b) inability to work or be active, (c) having aches and pains or a headache or stomach ache, (d) lacking energy, weakness, or malaise, and (e) sadness or feeling like they would rather be dead. Health-seeking behaviors described include (a) going to a doctor, (b) using herbal teas, (c) resting, (d) taking medication, and (e) drinking fluids. Typically, home remedies such as herbal teas, massage, baths, and poultices would be tried first; if these were not successful, then a doctor would be consulted. Participants identified as the most common reason for delaying treatment from a physician was the cost of services.

In their study of the effects of gender of closely related/associated people on the health-seeking behavior of people of the opposite sex, Norcross, Ramirez, and Palinkas (1996) found men 2.7 times more likely than women to be influenced to seek health care by a member of the opposite sex. Usually wives were most influential. Of married participants, they found that they were 2.4 times more likely than unmarried participants to be influenced by a member of the opposite sex to seek out health care. Norcross et al. concluded that women, especially wives act as "cultural health care brokers," exerting great influence on men's decisions to seek health care (p. 478). They also stated that men need to be educated to be more responsible for seeking appropriate and timely health care.

Vega, Kolody, and Aguilar-Gaxiola (2001) examined the issue of help-seeking behavior for mental health issues among Mexican Americans and reported that not much has changed in the 25 years between their study and a report by Padilla and Ruiz (1973) for the National Institute for Mental Health. They found in their review of the literature since the 1973 report that there is underutilization and gaps in treatment of the Hispanic population and that it is heighten among immigrant populations. Additionally, they reported there is disparity in utilization among the various Hispanic nationality groups. They reported that Cubans in Southern Florida use mental health services at higher rates than other Hispanic subgroups. Accordingly, this may be related to their having a higher socioeconomic status and living within an "enclave" where there are more Cuban American physicians. They further reported that Puerto Ricans in Puerto Rico have the lowest level of utilization. They identified Mexican Americans as also having serious utilization issues (Alegria et al., 1991; Portes, Kyle, & Eaton, 1992). For those groups reporting low levels of mental health utilization, they reported several factors contributing to the issue: (a) low socioeconomic status, (b) low insurance coverage, (c) local provider characteristics, and (d) language difficulties (Alegria et al., 2000).

Vega et al. (2001) using data from a household survey (the Mexican American prevalence and services study) of 3,000

participants in Fresno County, CA examined three issues (a) contrast use across multiple sectors of care among immigrant and U.S. born Mexican Americans with recent history of psychiatric disorders, (b) multiple provider utilization patterns, and (c) identification of specific factors associated with the use of mental health and general medical providers. They found that U.S. born Mexican Americans rely more heavily on family physicians and counselors for treatment than foreign born immigrants. Additionally, they found immigrants relied more heavily on informal networks such as family and friends for treatment of mental health issues. On comparing patterns, they determined that people with a recent disorder use a combination of providers. Key in their findings was the discovery that overall 80% of the foreign born receive no treatment or other assistance including informal assistance for their mental health issues (p. 139).

In examining the differences in help-seeking strategies among Hispanic and Euro-American dementia caregivers, Valle, Yamada, and Barrio (2004) interviewed 89 caregiver-care recipient pairs. They found that Hispanic caregivers were usually younger; fewer educated and had less monthly income than Euro-American caregivers. Their major finding was that Hispanic caregivers reported fewer people in their social networks and fewer help-seeking behaviors than Euro-American. When looking specifically at the help-seeking behavior of the two groups, Valle et al. found that Latinos were less willing to seek out advice or assistance from those outside of their social network, and it was reported they were more reluctant to discuss issues and seek advice from their social network than Euro-Americans. The lower use of their informal network by Latinos does not imply that they used formal networks of health providers more, rather that they were simply less willing to seek out assistance. The findings of Vega, Yamada, and Barrio suggest there may be cultural mechanisms in place that underlay significant ethnic differences in social network help-seeking behaviors of the two ethnic groups.

Of the cultural mechanisms in place, there may be a strong sense of filial obligation and a sense of burden that may manifest itself as a feeling of shame in admitting to these feelings, which they regard as inappropriate. Additionally, caregivers may not want to seek out help from their informal support structure because they do not want to burden the family. Finally, their reluctance to seek out help and assistance may be related to cultural attributions of dementia as a normal experience of aging (Valle et al., 2004).

Sobralke (2004) examined the health-seeking behavior of Mexican American men in Washington State. She did an ethnographic study of south-central Washington and interviewed eight men about their health-seeking behavior. In her study, she found that the Hispanic men in the area had varying levels of acculturation, number of years living in the state and in the United States, levels of education, cultural values, and ethnic identity. Sobralke determined that the "area had an interesting mix of traditional Mexican American cultural

values and values assimilated from the dominant society" (p. 207). She further determined that gender influences health care-seeking behavior—being a man requires fulfilling cultural obligations to family, friends, employers, coworkers, and the community. She determined that family and friends, especially wives, play an important role in Hispanic men's health-seeking behavior. Finally, the dominant type of health care sought and used was the dominant allopathic health care system.

The issue of health/help-seeking behavior is complex and not simply an issue of the ability to access care. The literature concerning health-seeking behavior and Latinos demonstrates several aspects: (a) the influence of the family cannot be undervalued, (b) wives in particular are key to influencing health-seeking behavior among men, (c) Latinos weigh options for seeking care that other cultural groups do, and (d) social economic status plays a major role in health-seeking behavior. Additionally, as has been previously pointed out, socialization of men, along with the issues raised in this section, imply that health-seeking behavior has many facets that need to be taken into account when planning and determining how to affect the health care of Latinos.

SUMMARY

Although there is ample evidence to suggest that access to health care by Latinos is severely compromised, a review of studies on this subject reveals that the findings are not always consistent. For example, a study by Shurr and Feldmen (2002) found that although Anglos were more likely than other groups to have either private insurance or Medicare, the disparities in access experienced by Latinos could not be attributed solely to lack of insurance and restricted access to health care. Two additional studies identified that even when insured, Latinos were less likely to visit a physician's office or access preventive services, such as vaccinations (Berk & Schur, 2001; Wallace & Villa, 2003). Thus, although it would be easy to conclude that disparities in access to care experienced by Hispanic populations are the result of unyielding, ethnocentric health care systems and the mitigating variables of socioeconomic status, sex, language differences, economics/insurance status, migrant status, environmental exposure, and lifestyle, these variables do not always perform as expected (HIV/AIDS Among Hispanics/Latinos in the United States, 2007; Plowden & Miller, 2000; Poss, 1999; Shedlin & Shulman, 2004; Smedley et al., 2003; U.S. Department of Health and Human Services, 2000b).

Alternative explanations have been reported in the literature for disparities in access, such as male role socialization and the social construct of masculinity (Addis & Mahalik, 2003; Galdas et al., 2005). Galdas et al., for example, concluded that social position and occupation were contributing factors to males' health-seeking behaviors and that the lower a man's educational level and economic status, the less frequently he sought nonemergent services, such as office visits, and the more he relied on emergency room services.

These findings indicate that although some studies have explained ethnic differences in access to health care by references to ethnicity, there may be additional, more subtle factors, such as gender, education, and position in the community, that are masked by assertions of ethnic homogeneity. Moreover, an often-unresponsive health care system may further compromise the access of men of color to effective health care.

In the search for explaining disparities in access to health services, the existing literature has attempted to identify patterns of health-seeking behavior, characteristics of an unresponsive provider system, as well as characteristics of the users. The results of the research, however, remain inconclusive and have not been particularly useful for creating public policy to ensure equal access to health care. The inability to draw policy-relevant conclusions from the literature may be attributed at least in part, to methodological dimensions—specifically (a) the tendency to compare Latinos, as a group with other ethnic groups and (b) the artificial separation of the user from the context. The work of Galdas et al. (2005) concerning men's health-seeking process is instructive. Although the focus was on sex rather than ethnicity, their review of a large body of literature pertaining to sex differences in health-seeking behavior identified several contradictions when comparing male and female health-care choices, making it difficult, if not impossible, to draw useful inferences. They concluded that the sex comparisons they reviewed often did not take into account biological, economic, psychological, or cultural processes responsible for observed differences (Galdas et al., 2005). They further concluded that studies of men's health/help-seeking behaviors needed to focus on intragroup behavior to yield a greater understanding of how individuals access health care.

Previous studies lack the benefit of intracultural comparisons addressing biological, socioeconomic, and psychological variables; these studies have failed to describe the health-seeking behaviors of Latinos in a manner that would help practitioners and policy makers to meet their needs by implementing appropriate health care strategies and interventions. Therefore, further research examining intracultural differences is needed to fill the gap in the existing literature and ensure that public attention is paid to health disparities among Latino men.

REFERENCES

- Adams-McDarty, K. (1996). Perceptions of health and illness in Mexico. *Journal of Multicultural Nursing & Health, 2*(2), 18-22.
- Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*, 5.
- Alegria, M., Kessler, R., Bijl, R., Lin, E., Heeringa, S. G., et al. (2000). Comparing data on mental health service use between countries. In G. Andrews & S. Henderson (Eds.), *Unmet need for treatment* (pp. 97-118). Cambridge, England: Cambridge University.
- Alegria, M., Robles, R., Freeman, D. H., Vera, M., Jamenez, A. L., et al. (1991). Patterns of mental health utilization among island Puerto Rican poor. *American Journal of Public Health, 90*, 608-614.
- Andrulis, D. P. (1998). Access to care is the centerpiece in the elimination of socioeconomic disparities in health. *Annals of Internal Medicine, 129*, 412-416.
- Applewhite, S. L. (1995). Curanderismo: Demystifying the health beliefs and practices of elderly Mexican Americans. *Health and Social Work, 20*, 247-253.
- Berk, M. L., & Schur, C. L. (2001). The effect of fear on access to care among undocumented Hispanic immigrants. *Journal of Immigrant Health, 3*, 151-156.
- Bolen, J., Rhodes, L., Powell-Griner, E., Bland, S., & Holtzman, D. (2000). State specific prevalence of selected behaviors, by race and ethnicity—behavioral risk factors surveillance system, 1997. *MMWR Surveillance Survey, 49*(SS02), 1-60.
- Brown, E. R., Wyn, R., & Teleki, S. (2000). *Disparities in health insurance and access to care for residents across U.S. cities*. Los Angeles, CA: The Commonwealth Fund and the UCLA Center for Health Policy Research.
- Burk, M. E., Wiesner, P. C., & Keegan, L. (1995). Cultural beliefs and health behaviors of pregnant Mexican American women: Implications for primary care. *Advances in Nursing Science, 17*(4), 37-52.
- Campbell, D. S. (1999). Health hazards in the meatpacking industry. *Occupational Medicine, 14*, 351-372.
- Carlisle, D., & Leake, D. (1997). Racial and ethnic disparities in the use of cardiovascular procedures: Associations with type of health insurance. *American Journal of Public Health, 87*, 263-265.
- Clark, M. (1959). *Health in Mexican-American culture*. Berkeley, CA: University of California Press.
- Congress, E. P. (1992). Cultural differences in health beliefs: Implications for social work practice in health care settings. *Social Work in Health Care, 17*, 81-96.
- Donham, K. J. (1990). Health effects from work in swine confinement buildings. *American Journal of Industrial Medicine, 17*, 17-25.
- Donham, K. J., Leistikow, B., Merchant, J., & Leonard, S. (1990). Assessment of U.S. poultry worker respiratory risks. *American Journal of Industrial Medicine, 17*, 73-74.
- Donham, K. J., Rubino, M., & Thedell, T. (1977). Potential health hazards to agricultural workers in swine confinement buildings. *Journal of Occupational Environmental Medicine, 19*, 383-387.
- Dreher, M. C., & MacNaughton, N. (2002). Cultural competence in nursing: Foundation or fallacy? *Nursing Outlook, 50*, 181-186.
- Dressler, W. W. (1988a). *Hypertension and cultural change: Acculturation and disease in the West Indies*. South Salem, NY: Redgrave Publishing.
- Dressler, W. W. (1988b). Social consistency and psychological distress. *Journal of Health and Social Behavior, 29*, 79-91.
- Dressler, W. W. (1993). Social and cultural dimensions of hypertension in Blacks: Underlying mechanisms. In J. C. S. Fray & J. G. Douglas (Eds.), *Pathophysiology of hypertension in Blacks* (pp. 69-89). New York: Oxford University Press.
- Dressler, W. W. (1994a). Social status and the health of families: A model. *Social Science and Medicine, 39*, 1605-1613.
- Dressler, W. W. (1994b). Social status, age, and blood pressure in an English general practice. *Colloquium of Anthropology, 18*, 73-80.
- Dressler, W. W., & Bindon, J. R. (1997). Social status, social context, and arterial blood pressure. *American Journal of Physical Anthropology, 102*, 55-66.
- Dressler, W. W., Santos, J. E. D., Gallagher, P. N., & Viteri, F. E. (1987). Arterial blood pressure and modernization in Brazil. *American Anthropology, 89*, 389-409.
- Drevdahl, D. (1999). Meanings of community in a community health center. *Public Health Nursing, 16*, 417-425.
- Engelbreton, J. (1994). Folk healing and biomedicine: Culture clash or complimentary approach? *Journal of Holistic Nursing, 12*(3), 240-250.
- Evans, R. G., Barer, M. L., & Marmor, T. R. (1994). *Why are some people healthy and others not? The determinants of health of populations*. Hawthorne, NY: Aldine De Gruyter.

- Fink, D. (1998). *Cutting into the meatpacking line. Workers and change in the rural midwest*. Chapel Hill, NC: University of North Carolina.
- Fiscella, K., & Franks, P. (1997). Does psychological distress contribute to racial and socioeconomic disparities in mortality? *Social Science and Medicine*, 45, 1805-1809.
- Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: Literature review. *Journal of Advanced Nursing*, 49, 616-622.
- Grey, M. (1997). Storm Lake and the meatpacking revolution: Historical ethnographic perspectives on a community in transition. In S. Stromquist & M. Bergman (Eds.), *Unionizing the jungles, labor and community in the twentieth century meatpacking industry*. Iowa City, IA: University of Iowa Press.
- Grey, M. (1999). Immigrants, migration and worker turnover at the hog pride pork-processing plant. *Human Organizations*, 58(1), 16-27.
- Hamburg, M. (1998). Eliminating racial and ethnic disparities in health. *Public Health Reports*, 118, 372-375.
- Harrell, J., & Carrasquillo, O. (2003). The Hispanic disparity in health coverage. *JAMA*, 289, 1167.
- Health Insurance Coverage. (2001). Retrieved November 5, 2003, from www.census.gov/hhes/hlthin/hlthin02/hlthin02asc.html
- Hedges, S., Hawkins, D., & Loeb, P. (1996). Immigrants in Midwestern meatpacking. *Rural Migration News*, 3(4). Retrieved September 24, 2007 from http://www.migration.ucdavis.edu/rmn/more.php?id=144_0_2_0
- HIV/AIDS Among Hispanics/Latinos in the United States. (2007). Retrieved September 24, 2007 from <http://www.cdc.gov/hiv/resources/factsheets/hispanic.htm>
- Hoppe, S. K., & Heiler, P. L. (1975). Alienation, familism, and utilization of health services by Mexican Americans. *Journal of Health and Social Behavior*, 16, 304-314.
- Iowa Department of Public Health. (2001). *Survey and analysis of the health needs and disparities of the immigrant population* (Government Public Health Report). Des Moines, IA: Iowa Department of Public Health, Primary care Office, Bureau of Rural Health and Primary Care, Iowa/Nebraska Primary Care Association, University of Northern Iowa Global Health Corps, Proteus, Inc., State Public Policy Group, Inc.
- Johnson, E. S., Dalmas, D., Noss, J., & Matanoski, G. (1995). Cancer mortality among workers in abattoirs and meatpacking plants: An update. *American Journal of Industrial Medicine*, 27, 389-403.
- Kay, M. A. (1977). Health and illness in a Mexican American barrio. In E. H. Spicer (Ed.), *Ethnic medicine in the Southwest* (pp. 99-166). Tucson, AZ: University of Arizona Press.
- Keefe, S. E. (1982). Help-seeking behavior among foreign-born and native-born Mexican Americans. *Social Science and Medicine*, 16, 1467-1472.
- Keegan, L. (1996). Use of alternative therapies among Mexican Americans in the Texas Rio Grande Valley. *Journal of Holistic Nursing*, 14(4), 277-294.
- Kellogg, W. K. (2003). Saving our men: A wake up call to end America's silent health crisis. The State of men's health. *A public education booklet* (pp. 1-30).
- Larkey, L. K., Hecht, M. L., Miller, K., & Alatorre, C. (2001). Hispanic cultural norms for health-seeking behaviors in the face of symptoms. *Health Education & Behavior*, 28(1), 65-80.
- Lawrence, V. A., & Tuley, M. (1996). Appendicitis: Higher risk in Mexican Americans? *Ethnicity and Health*, 1(3), 237.
- Martaus, T. M. (1986). The health-seeking process of Mexican-American migrant farm workers. *Home Healthcare Nurse*, 4(5), 32-38.
- McKenna, M. A. (1989). Transcultural perspectives in the nursing care of the elderly. In J. S. Boyle & M. M. Andrews (Eds.), *Transcultural concepts in nursing care* (pp. 189-220). Boston: Scott Foresman.
- Molina, C. W., Zambrana, R. E., & Aguirre-Molina, M. (1994). The influence of culture, class and environment of health care. In C. W. Molina & M. Aguirre-Molina (Eds.), *Hispanic health in the US: A growing challenge*. Washington, DC: American Public Health.
- Mueller, K. J., Ortega, S. T., Parker, K., Patil, K., & Askenazi, A. (1999). Health status and access to care among rural minorities. *Journal of Health Care for the Poor and Underserved*, 10(2), 230-247.
- Murray, L. R. (2003). Sick and tired of being sick and tired: Scientific evidence, methods, and research implications for racial and ethnic disparities in occupational health. *American Journal of Public Health*, 93, 221-226.
- National Cancer Institute. (2001). *Surveillance, epidemiology, and end results (SEER), annual report to the nation on status of cancer, 1973-1998*. Bethesda, MD: National Cancer Institute.
- Nicholas, D. (2000). Men, masculinity, and cancer: Risk-factor behaviors, early detection, and psychosocial adaptation. *Journal of American College Health*, 49(1), 27-33.
- Norcross, W. A., Ramirez, C., & Palinkas, L. A. (1996). The influence of women on the health care seeking behavior of men. *Journal of Family Practice*, 43, 475-480.
- Padilla, A. M., & Ruiz, R. A. (1973). *Hispanic mental health*. Rockville, MD: National Institute for Mental Health.
- Plowden, K. (2003). A theoretical approach to understanding Black men's health-seeking behavior. *Journal of Theory Construction & Testing*, 7(1), 27-31.
- Plowden, K. O., & Miller, J. L. (2000). Motivators of health seeking behavior in Urban Africa-American men: An exploration of triggers and barriers. *Journal of National Black Nurses Association*, 11(1), 15-20.
- Portes, A., Kyle, D., & Eaton, W. W. (1992). Mental illness and help seeking behavior among Mariel Cuban and Haitian refugees in south Florida. *Journal of Health and Social Behavior*, 33, 283-298.
- Poss, J. E. (1999). Developing an instrument to study the tuberculosis screening behaviors of Mexican migrant farm workers. *Journal of Transnational Nursing*, 10, 306-310.
- Quinn, K. (2000). *Working without benefits: The health insurance crisis confronting Hispanic Americans*. Retrieved November 5, 2003, from http://www.commonwealthfund.org/usr_doc/quinn_wobenefits_370.pdf?section=4039
- Ramos-Sanchez, L. (2000). *The relationship between acculturation, specific cultural values, gender, and Mexican Americans' help seeking intentions*. Unpublished Doctoral Dissertation, University of California, Santa Barbara, CA.
- Rich, J. A., & Ro, M. (2002). *A poor man's plight: Uncovering the disparity in men's health*. Battle Creek, MI: W.K. Kellogg.
- Ro, M. J., Casares, C., Treadwell, H., & Thomas, S. (2004). *A man's dilemma: Healthcare of men across America, a disparities report*. National Center for Primary Care at the Morehead School of Medicine.
- Schiavenato, M. (1997). The Hispanic elderly: Implications for nursing care. *Journal of Gerontological Nursing*, 23(6), 10-15.
- Shedlin, M. G., & Shulman, L. (2004). Qualitative needs assessment of HIV services among Dominican, Mexican and Central American immigrant populations living in the New York City area. *AIDS Care*, 16, 434-445.
- Shurr, C., & Feldmen, J. (2002). *Running in place: How job characteristics, immigration status and family structure keep Hispanics uninsured*. Retrieved November 5, 2003, from http://www.commonwealthfund.org/usr_doc/schurr_running_453.pdf?section=4039
- Skaer, T. L., Robinson, L. M., Sclar, D. A., & Harding, G. H. (1996). Utilization of curanderos among foreign born Mexican-American women attending migrant health clinics. *Journal of Cultural Diversity*, 3(2), 29-34.
- Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). *Unequal treatment: Confronting racial and ethnic disparities in healthcare*. Washington, DC: National Academies Press.
- Smith, A. (2003). Health policy and the coloring of an American male crisis: A perspective on community-based health services. *American Journal of Public Health*, 93, 749-752.

- Sobralse, M. C. (2004). *Health care seeking beliefs and behaviors of Mexican American men living in south central Washington*. Unpublished doctoral dissertation, Gonzaga University. Retrieved October 24, 2007, from ProQuest Digital Dissertations database. (Publication No. AAT 3133619).
- Staveteig, S., & Wigton, A. (2000). *Racial and ethnic disparities: Key findings from the national survey of America's Families*. Retrieved October 20, 2001, from <http://www.urban.org/publications/309308.html>
- Timmins, C. L. (2002). The impact of language barriers on the health care of Latinos in the United States: A review of the literature and guidelines for practice. *Journal of Midwifery & Women's Health, 47*(2), 80-96.
- UFCW. (2005). *Responding to AFL-CIO, UFCW lawsuit, Bush administration agrees to issue safety equipment rule for employers*. Retrieved September 24, 2007 from http://www.ufcw.org/press_room/index.cfm?pressReleaseID=303
- U.S. Bureau of the Census. (2004). *Statistical abstract for the United States*. Retrieved March 9, 2006, from <http://www.census.gov/prod/www/statistical-abstract.html>
- U.S. Department of Health and Human Services. (2000a). *Healthy people 2010* (1st ed.). McLean, VA: International Medical Publishing.
- U.S. Department of Health and Human Services. (2000b). *Oral health in America: A report of the surgeon general*. Rockville, MD: National Institute of Dental and Craniofacial Research, National Institute of Health.
- Valle, R., Yamada, A. M., & Barrio, C. (2004). Ethnic differences in social network help-seeking strategies among Hispanic and Euro-American dementia caregivers. *Aging & Mental Health, 8*, 535-543.
- Vega, W. A., Kolody, B., & Aguilar-Gaxiola, S. (2001). Help seeking for mental health problems among Mexican Americans. *Journal of Immigrant Health, 3*(3), 133-140.
- Wallace, S. P., & Villa, V. M. (2003). Equitable health systems: Cultural and structural issues for Hispanic elders. *American Journal of Law and Medicine, 29*, 247-267.
- White-Means, S. I. (2000). Racial patterns in disabled elderly persons' use of medical services. *Journal of Gerontology, 55*, 576-589.
- Willis, D. J. (2002). Introduction to the special issue: Economic, health, and mental health disparities among ethnic minority children and families. *Journal of Pediatric Psychology, 27*, 309-314.
- Yehieli, M., Joslyn, S., Mukeshimana, C., Dobie, S., Gonnerman, M., & Lutz, G. (2001). *Assessing the public health status of newcomers: A report on Bosnian and Hispanic immigrants in Black Hawk County, Iowa*. Cedar Falls, IA: The Center for Social and Behavioral Research and The Global Health Corps, University of Northern Iowa.

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