

Virtual Seminar on Persistent and Large Racial/Ethnic Disparities: Beyond the Role of Socioeconomic Status (SES)

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Committee on Population (CPOP) Semi-Annual Meeting

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Web Conference

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Meeting Summary

Introduction

The most recent National Advisory Council on Aging (NACA) review advised the National Institute on Aging Division of Behavioral and Social Research (NIA BSR) to increase and improve research into health disparities in aging across race/ethnicity, socioeconomic status (SES), and immigration status. On May 18, 2020, the National Academies of Sciences, Engineering, and Medicine's Committee on Population (CPOP) convened a seminar for NIA BSR that explored new approaches to understanding persistent and large racial and ethnic disparities beyond a pure socioeconomic framework.

This half-day meeting reviewed recent research in four broad areas: race and ethnicity and U.S. health disparities; lifecourse stress, discrimination, and other negative exposure risks; intergenerational mobility and racial and ethnic health disparities; and immigration and racial and ethnic health disparities.

Following the presentations, seminar participants engaged in a wide-ranging discussion of research priorities and gaps. Four main themes emerged from these discussions:

- Social science needs rigorous models of how social inequity is embodied in poor health outcomes in order to create a clear framework for the development of national, state, and local public policies that can achieve the goals of human rights, social justice, and dignity.
- Intersectional research is needed to understand the multiple dimensions affecting subgroups of racial and ethnic minorities (e.g., differences between Black men and Black women, Caribbean and sub-Saharan African immigrants, and native English speakers and non-native English speakers).
- Racial disparities appear in uneven data collection and must be overcome through the development of validated measures of mental and physical health; effective survey techniques that are not vulnerable to self-selection; adequate coding of historical data; and robust longitudinal studies to analyze relationships across individual lifespans, family relationships, social shifts, and birth cohorts.
- The biological expression of racism is complex, with nuanced outcomes linked to vigilance, resilience, upward mobility, and intergenerational mobility.

Given the longstanding structural racism in the United States, health disparities are a persistent challenge. Research to increase understanding and identify effective strategies to reduce those disparities will remain critically important in the coming years.

Session 1: Overview of the Issues: Race/Ethnicity, Moving Beyond SES, and U.S. Health Disparities

Structural Racism, Class Injustice, and Embodied Health Inequities: Both/And Not Either/Or

Nancy Krieger, Harvard University

Population health researchers should explore the intersection of racism and health for two main reasons. First, assessing the adverse impact of racism on health is one essential part of monitoring population health, analyzing its determinants, and providing evidence for public health action. Second, understanding the impact of racism on the *science* of population health is crucial for improving rigor and avoiding error in the field. The ultimate goal of addressing the intersection of racism and health is to provide information about health disparities, which are unfair, avoidable, and preventable.

History of Scientific Racism

Scientific racism has a long history, from the notion of polygenesis (or distinct racial species) in the 1800s to the rise of eugenics at the turn of the 20th century. These sciences helped justify inequitable living and working conditions that, through the process of embodiment, resulted in the biological expression of racism and the racialization of biology. Ecosocial theory identifies the pathways of this embodiment and demonstrates how those pathways (which can include excess exposure to toxins and hazards, social trauma, health-harming responses to discrimination, and inadequate medical care) allow historical and contemporary injustice to exert ongoing public health impacts.

Jim Crow laws are one important historical source of contemporary racial health disparities, especially relevant to U.S. Black populations, in conjunction with other forms of racial discrimination occurring in both the Jim Crow and non-Jim Crow states. Anyone aged 55 years and older today was born during Jim Crow, and its practices are frequently measurable in their bodies. For example, Krieger and her team found that Black women born in Jim Crow states are more likely to have a more lethal variety of breast tumor (estrogen receptor-negative, or ER-, tumors) than those born in non-Jim Crow states. By comparison, no differences in ER- breast cancer rates exist in White women between Jim Crow and non-Jim Crow states. These findings exemplify the biological expression of racism.

Legacy of Scientific Racism

To better measure these racial inequities, in 2001 Douglas Massey developed the Index of Concentration at the Extremes (ICE), which he designed to measure spatial social polarization for economic variables (e.g., income, education) that can be computed at multiple scales and geographic levels. Krieger extended use of the ICE to quantify both racial/ethnic spatial polarization and, combining racial/ethnic and economic data, a new measure of racialized economic segregation (i.e., the measure of race *and* economics). Using this measure, Krieger has uncovered larger health inequities than other researchers' individual applications of ICE for race or economics alone, particularly at the census-tract level. For example, Krieger's research

has shown that racialized economic segregation most sensitively captures inequities in infant and child mortality; premature mortality; all-cause mortality; cause-specific mortality for diabetes, cardiovascular disease, and cancer; cancer incidence; deaths due to smoking; fatal and nonfatal assaults; and police killings. Moreover, this measure can analyze the contribution of historical racism to contemporary public health outcomes, such as the impact of redlining on risk of preterm birth.

The COVID-19 pandemic reflects the continued impact of racial and ethnic disparities. The Centers for Disease Control and Prevention (CDC) and state health reports on COVID-19 testing and hospitalization include little to no racial and ethnic data, but researchers have compared racial and ethnic composition of cases versus the total population to show that populations of color are overrepresented among those deaths attributed to COVID-19. Possible explanations for this disparity include how racism and poverty structure increased risk of exposure (through inadequate paid sick leave, use of public transit, and place of work) and severity of illness (due to socially structured comorbidities). The stark gaps in COVID-19 surveillance data speak to failures to take racial and ethnic and socioeconomic health inequities seriously. This current work illustrates the need to continue to address both structural racism and class injustice when analyzing causal pathways of health inequality.

Discussion

Current Landscape

To address the impact of historical inequities, public policy should be centered on human rights, economic justice, and dignity, and should be as integrated and interconnected as people's embodied experiences. Transportation, economic, housing, and other policy are all integrated in people's bodies, and some movements capture this fact—for example, the Poor People's Campaign offers an expansive health equity agenda that links economic, racial, environmental, and reproductive justice.

Measuring Historical Effects

The impact of historical racism sometimes varies surprisingly across measures. To analyze these differences, researchers should employ imaginative approaches to historical data collection that goes beyond codified law, which of course does not fully capture people's lived experience (e.g., sanitation access, which is highly relevant to public health) in a uniform way. Moreover, researchers should account for these differences by observing the structured pathways by which oppression has carried through to modern society.

Redlining data, in particular, must become more accessible to be integrated into public health research. Researchers follow vastly different approaches to make redlining visible in historical maps, with some adding percentage redlined and others registering continuous or categorical redlining grades. Some researchers are working with urban planners to fill in missing historical data on areas not included in historical maps. The urban planners help explore how trajectories from the surrounding areas have influenced the newly built-up neighborhoods to consider how the effects of the past have carried into the present.

Impact of Structural Racism and Wealth on Health Outcomes

Researchers lack high-quality data on the accumulation of wealth across minority and non-minority groups and its impact on health disparities. Inheritance has always been structured by policies that put minority groups at a disadvantage. Researchers in the United States are beginning to collect better data on wealth and inheritance in minority populations, by adding wealth questions to surveys, using the Panel Survey of Income Dynamics, and seeking resources outside of the United States, such as the Luxembourg Income Study.

Session 2: Lifecourse Stress, Discrimination, and Other Exposures

Racial Health Inequalities Revisited: The Toxic Burden of Cultural Racism

Margaret Hicken, University of Michigan

Racism is a political system of formal and informal rules within which members of the dominant group create or accept their social privilege by maintaining structures, ideologies, values, and behavioral norms; it is also ultimately a tool that allows society to regulate the distribution of death. Deeply embedded racism is expressed through cultural racism (the shared understanding of who is worthy of full symbolic or legal citizenship based on racialized group membership). Cultural racism acts as a distortion lens that makes racialized and racially-hierarchical institutions seem neutral and rational. Structural racism, then, is actualized in the form of cultural racism. Structural racism is maintained through the strong, symbiotic, resilient connections among institutions. Cultural and structural work have persisted because they include the erasure of historical processes that could clarify the link between racialized groups and health.

The transgenerational perpetuation of cultural racism drives the continuation of structural racism. Cultural racism also creates stigmatizing stereotypes that press members of marginalized groups to adapt to an oppressive societal structure. These adaptations manifest in marginalized groups as vigilance, which takes three main forms: impression management (i.e., do I appear threatening and are my statements valid, factual, and original), social avoidance (i.e., consideration of when and where to engage in spaces predominantly traversed by the dominant social class), and preparation for slights (i.e., anticipating negative interactions with individuals of the dominant social class whether due to past experience or shared experiences through social connections).

This vigilance leads to two types of stress response. The first is anticipatory stress: the activation of the biological stress response in anticipation of a potentially stressful situation. Anticipatory stress is a normal part of human physiology, but *chronic* anticipatory stress may result in disfunction of the stress response system. The second stress response, ruminative stress, results from prolonged reflection on a stressful situation. Through repeated or long-term rumination, an *acute* stressor can transform into a *chronic* stressor that repeatedly activates the biological stress response system.

Physical manifestations of vigilance can be observed when monitoring the stress response of Black women in a commonly stressful environment: a job interview. In a study of healthy Black

women, Hicken measured stress responses before, during, and after a social stress test based on a job interview in front of potential employers; the panel varied in racial composition (Black or White women) and perspectives about Black Americans (hostile, friendly). She found that Black women who spoke to a panel composed of potential employers who were White and held racially hostile attitudes had higher anticipatory, performing, and post-performance blood pressure. This finding suggests that vigilance activates the stress response system both in anticipatory and ruminating ways. Vigilance and the related stress reactions are linked to health outcomes, including incidence of hypertension, sleep difficulty, obesity, mental health, and physical health. Therefore, vigilance is one way through which cultural racism negatively impacts the health of Black Americans.

Racial Health Inequalities in Context

Sharelle Barber, Drexel University

Structural racism, a major driver of health inequalities among minority groups, is the key enabler of racial residential segregation (the convergence of place and structural racism, which manifests in disparate health outcomes through unhealthy socioeconomic, built, and social environments). Exposure to these unhealthy environments leads to lower socioeconomic class, acute and chronic stress, poor health behaviors, and exposure to infections and toxicants.

Racial residential segregation is illustrated by how often minority families who have obtained middle-class status live in areas where average SES is below the means of White middle-class individuals. A study showed that Black households with income of \$100,000 tend to live in neighborhoods where the median household income is only \$54,000. By living in areas below their means, minority families are at a disadvantage because neighborhoods are influential in shaping health and wellness of residents (via inequitable access to grocery stores, healthcare facilities, and schools).

To further illustrate this point, Barber has used the Jackson Heart Study to analyze how structurally racist policies continue to impact the health of minority populations today. The Jackson Heart Study is one of the largest single-site studies of Black Americans. When comparing cardiovascular disease rates in individuals in most and least disadvantaged neighborhoods, Barber and her team found that individuals from the least disadvantaged neighborhoods have lower levels of cardiovascular disease. However, when cross-compared with educational attainment, cardiovascular disease rates were similar among individuals with less than a high school education regardless of neighborhood disadvantage. It was only at the higher levels of education that the effects of disadvantaged neighborhoods became more pronounced. Researchers have applied mathematical formulas to illustrate that Black communities have experienced a variety of disadvantages (socially and economically) because of disinvestment in these neighborhoods over the past decades.

Discussion

Scalability of Approaches

Although Hicken and her team implemented vigilance measures in experimental studies, psychologists have developed a survey to measure vigilance that can be implemented in the large population studies sponsored by NIA. This six-item survey measure asks about aspects of vigilance such as how often individuals consider their appearance or prepare for insults. Since 2000, the measure has been implemented in the Americans' Changing Lives study, Detroit Area Study, and others. Results from these studies have reinforced the relationship between disease incidence, racial inequalities, and reports of vigilance.

Strengths of Neighborhood-Level Measurements

Although studies of neighborhoods capture single moments of racial inequality, the limited mobility of minority populations can create a cross-study cumulative amalgam of data that can be used to study stress exposure. The valuable insight that can be gained from this data is one reason that neighborhoods are such powerful markers for measuring cumulative biological risk in minority populations. Neighborhoods may also help account for health differences between women and men, who interact with and navigate their communities in different ways and may thus be exposed to different factors that lead to varying health outcomes. Further studies are needed to determine these effects.

When considering local statistics, it may also be worth studying the intersection of segregation and access to specific health care opportunities. It may be possible to link a measure of health care access to neighborhoods by leveraging the Dartmouth Health Atlas or Area Resource File to determine the number of primary care providers or other health care facilities in a zip code.

Vigilance Effects on Mental Health

In addition to the physiological responses to vigilance, researchers see similar mental health impacts in minority populations. The studies measuring vigilance and mental health outcomes tend to rely on self-report. However, evidence shows that vigilance is a distinct construct for Black populations—unlike for White populations, where it maps onto other personality and mental health constructs.

Removing Structural Racism

Given the deep-seated racism in American policies and perspectives, change can seem impossibly challenging. However, social structures that seem immovable are human creations, which means they can be *re-created*. Science has a key role to play in this re-creation, as it analyzes the workings of large-scale and intersectional systems that produce racial inequities—including economic exploitation, ecological damage, and health care injustice. In this work, science is a partner to social movements that must unfold at the federal, state, and local levels.

Session 3: Intergenerational Mobility and Racial/Ethnic Health Disparities

Intergenerational Mobility and Racial/Ethnic Health Disparities

Lauren Gaydos, Vanderbilt University

The effect of intergenerational mobility is an area of interest for researchers examining racial and ethnic health disparities. For the purpose of this discussion, Gaydos focused on minority populations in early adulthood (ages 18-30s) for several reasons: individuals in this age range are less subject to selective mortality, have achieved mobility, and their choices and mobility set health and aging trajectories. Further, the prospective data for this age group is rich.

Effects of Early Life Disadvantage

When analyzed by both education and race and ethnicity, life expectancy estimates of 25-year-olds show a pattern of diminishing returns, particularly among women, with White women gaining 9 years by achieving the highest education level, Black women gaining 5 years for the same achievement, and Hispanic women gaining only 3 years for the same accomplishment.

One theory for these diminishing returns is that early life disadvantages actually suppress later life benefits afforded by mobility. Such early life disadvantage may include loss of a family member, incarceration of a family member, or being raised in a single parent household from birth. This theory is illustrated by research completed in the National Longitudinal Study of Adolescent to Adult Health (Add Health). As part of this national population study, researchers compared metabolic syndrome rates for individuals compared across childhood background and college completion. For White and Hispanic individuals, college completion is associated with fewer metabolic health issues, regardless of childhood advantage or disadvantage. The same does not hold true for Black individuals.

When tracked across the lifecourse, college completion consistently results in lower metabolic syndrome rates for White individuals. However, for Black and Hispanic individuals, evidence suggests that upward mobility leads to no physical health benefit and may even lead to a health cost for the most disadvantaged individuals. Yet, regardless of racial and ethnic group, upwardly mobile individuals experience decreased symptoms of depression—especially the most disadvantaged Black individuals.

Reasons for Observed Patterns

There are three possible explanations for the “tax” that upward mobility imposes on the physical health of Black and Hispanic individuals: skin-deep resilience, discrimination, and educational contexts. Skin-deep resilience is the theory that Black and Hispanic individuals must engage in effortful coping and determination strategies that are psychologically protective but physiologically taxing. Discrimination is the theory that upward mobility may create more opportunities for exposure to racism. Even the anticipation of these experiences can lead to vigilance behaviors that have physiological consequences. Educational context is the theory that conventional socioeconomic indicators are not equivalent across races. Black and Hispanic college graduates are more likely to have attended poorer, lower ranked, and less resourced schools, which leads to differential returns from educational attainment compared

to their White peers. These early life disadvantages are a major reason why addressing continued race inequity is critical for aging minority communities.

Racial Disparities in the Link Between Offspring Education and Older Parents' Health

Jenjira Yahirun, Bowling Green State University

Past research on the socioeconomic gradient in health has focused on individual-level determinants and processes. When researchers addressed intergenerational mobility, they focused largely on downstream effects from parents to children. This single-direction perspective has created a gap in the research about whether upstream effects from children to parents exist, and specifically whether an adult child's upward mobility can impact their parents' health.

Role of Adult Child's Education on Older Parents' Health

Positive effects of children's education on parents' health may stem from four factors: financial support, shared fate (i.e., parents share the benefit of upward mobility), psychological rewards, or health spillovers (i.e., parents may mimic their children's healthier lifestyles or be educated to choose their own healthier lifestyles). However, these factors all require further study.

Research in this area must also consider whether upstream effects differ across racial and ethnic groups. For example, resource substitution would predict that parents with fewer resources—including disadvantaged racial and ethnic minorities—would take greater advantage of their children's resources. Conversely, resource multiplication predicts that White individuals would derive greater benefits from education by combining those benefits with their other social advantages. Other factors that may contribute to moderation of success by race include differences in kinship support (i.e., Black families are more likely to call upon one another for support than other racial groups) and academic aspirations (Black parents are more likely than White parents to express higher academic aspirations for their children, with 62 percent saying it is extremely important that their children earn a college degree).

Yahirun conducted a study to test some of these factors. The study examined data from the Health Retirement Study (HRS) on parents' depressive symptoms in relation to their children's completion of college. The analysis illustrated that parents with *all* children who attained college education had fewer depressive symptoms than those with *no* children who had attained college education; moreover, the effect was greater for Black than White parents. This protective effect appears to reverse at older ages, but at much later ages for Black parents compared to White parents (80s versus 70s).

Implications from Social Mobility Literature

Of course, the resource of children's college education is not distributed evenly among parents from different racial backgrounds. About 20 percent of White parents—compared to 9 percent of Black parents—see all of their children receive a college education, and about 40 percent of White parents—compared to 34 percent of Black parents—see at least some of their children complete a college education. These data, together with Yahirun's findings, help explain some continued racial disparities in immediate and long-term mental health.

By studying how population aging affects family-level health, particularly for older adults, researchers can continue to observe intergenerational mobility and health impacts to unpack the disparities that persistently impact racial and ethnic minorities, especially in later life.

Discussion

Measuring Mental Health Disparities

Current mental health measures have proven insufficient to identify the differences in severity of depression between Black and White individuals. Researchers could control for the difference by using the Center for Epidemiological Studies Depression (CES-D) measures validated across racial and ethnic groups. When applying only these measures, Black and Hispanic individuals show higher levels of depression compared to White individuals. The use of other mental health measures may prove to be no more useful because rates of depression, anxiety, and posttraumatic stress disorder (PTSD) show similar trends. Further, these other measures are limited because they rely on individuals who seek medical treatment.

The difference between the physiological cost and the psychological benefit of upward mobility is measured in different ways. While physiological cost is measured with biomarkers and other quantitative measures, psychological benefit is measured through self-report or qualitative measures. Therefore, psychological issues may be underreported by minority individuals, particularly among upwardly mobile individuals who are more likely to exhibit high vigilance. However, because there is still a signal of increased psychological costs across different studies and measures, the observed results are likely attributable to more than just error in depressive symptom scale.

Education Effects Over Time

Cohort effects may mediate the interpretation of health disparities. For example, the apparent reversal in benefits of children's education for older parents emerged from a comparison of multiple cohorts rather than from a longitudinal study. The observed effects of number of college-educated children may also become less prominent across birth cohorts, as high-SES parents have become increasingly likely to have a large number of children (compared to past decades when low-SES parents were likely to do so), and as parent-child relationships change across generations. Currently, data from HRS are not strong enough to enable study of these comparisons, but as longitudinal studies continue to produce more complete data on birth cohorts, researchers will become more capable of analyzing these questions.

Parents with college education also experience a similar dissipation of benefits from child education over time. This decrease occurs when cognitive decline is typical, and this decline exhibits few differences across racial populations. However, when stratified by parent education, Black parents with less than a high school education experienced significant protection against cognitive impairment from their children's education compared to Whites who also had less than a high school education. These preliminary results suggest that at the lower end of the socioeconomic distribution, Black parents tend to benefit more from the college education of their offspring than White parents.

Session 4: Intergenerational Mobility and Immigration, Context of Reception, and Racial/Ethnic Health Disparities

Health Disparities Among U.S. Blacks

Tod G. Hamilton, Princeton University

Immigration policy reforms made it easier for Black individuals to immigrate to the United States from the Caribbean starting in 1960 from Sub-Saharan Africa starting in 1990. Between 1960 and 2014, the number of Black immigrants in the United States increased by greater than 2,800 percent. By 2014, 9 percent of the Black population was foreign born. This immigration history has influenced the health of Black individuals in the United States.

Healthy Immigrant Effect

Upon arrival in the United States, immigrants tend to be healthier than their native-born counterparts. Researchers have posited that immigrant cultural practices (e.g., dietary practices, social support networks) and selective migration (i.e., healthier individuals tend to leave their country of origin) may explain this difference. However, as the duration of stay in the United States continues, the health of immigrants erodes. Researchers have posited that various aspects of the social environment (i.e., poor working conditions, exposure to discrimination, migration stress) may explain this trend. Hamilton's work strives to understand whether health and health trajectories vary among Black immigrants by period of arrival and region of origin.

To determine whether period of arrival affected immigrants' health, Hamilton measured health with an equation that uses multiple control vectors for variables such as arrival cohort and years living in the United States. In one application of this formula, he collected data from the Current Population Survey (CPS) to observe immigrant arrival waves between 1996 and 2010. Every immigrant population, regardless of arrival cohort, was less likely to report poor or fair health status than their native-born counterparts. However, when the data were disaggregated by country of origin, differences across arrival cohorts appeared. Africans who immigrated prior to 1985 were more similar in health status to their native-born counterparts than later arrivals. Caribbean immigrants' favorable health status over native-born counterparts persisted but at a declining rate between 1980 and 2010. Further evidence shows that the duration of U.S. residence had a negative impact on the health of Black immigrants, with increased length of stay leading to more responses of fair or poor health.

Conclusions

Arrival cohort differences may be due to changes to government policies, the host labor market, and/or features of the immigrants' ethnic communities. Dramatic changes to immigration policy since 1965 have, in turn, changed the composition of the immigrant population. Ignoring arrival cohort effects may lead to over- or under-estimation of the degree of health decline experienced by immigrants.

Differences between immigrant and native-born individuals may also provide context for better understanding the Black-White gap in health disparities. For example, most studies do not differentiate the health of Black immigrants and native-born Black individuals when investigating health outcomes. Yet, given that Black immigrants have proven to be a healthier population, researchers should account for immigration differences when measuring the health progress of Black individuals in the United States. Researchers must ensure that studies of health disparities consider detailed place of birth, parental birthplace, grandparent birthplace, detailed time of arrival, longitudinal studies, and binational research initiatives.

Latino/a Immigrant Health and Health Trajectories: Beyond Socioeconomic Factors

Carmela Alcántara, Columbia University

Latino/a immigrants account for 48 percent of the foreign-born U.S. population. The sociodemographic profiles of individuals from Mexico, Central America, South America, and the Caribbean substantially differ. The healthy immigrant effect is not consistent across Latino/a subgroups, but length of residence has a similar negative impact across Latino/a immigrant subgroups. For example, data published in *Diabetes Care* has shown that the prevalence of diabetes among Latino/a immigrants increases with time spent in the United States, and that Latino/a immigrants who lived in the United States for more than 10 years have a higher prevalence of diabetes than their U.S.-born counterparts.

Researchers have offered multiple potential explanations for the immigrant health paradox, immigrant health declines, and their variability across subgroups. These explanations can be split between psychosocial and behavioral, sociological, or methodological explanations. Alcántara focused on the psychosocial and behavioral aspects, specifically that increased stress exposure over time may increase the likelihood of engaging in health risk behaviors. In other words, over time immigrants suffer from challenges to successful acculturation (the process of adapting and integrating into a host culture), such as language, race, ethnicity, discrimination, family ties, and SES.

Beyond Socioeconomic Factors

Immigrants could potentially mitigate the stress of acculturation by maintaining ties to their country of origin. These ties, known as transnational ties, may take the form of return visits, remittances, or social media contact. Such ties may promote social support and sense of belonging, mark upward mobility through the ability to provide remittances, and buffer against social stress related to migration. However, these ties may also burden immigrants through cross-border caregiving (including emergency health-related travel back home), family separation, and mental health strain and social stress.

Many studies illustrate how transnational ties affect Latino/a immigrant health. Return visits have been associated with higher rates of smoking across all Latino/a immigrants. Although practiced differently among subpopulations, remittance have been associated with reduced depressive episodes. The potential for social mobility also affects the health of immigrants and is a chief factor in voluntary migration. Associations between depression and perceived social mobility (i.e., social status in America compared to country of origin) is significantly moderated

by country of origin, with higher rates of depression connected to downward social mobility for Puerto Ricans, stable social mobility for Cubans, and upward social mobility for other Latinos. In all instances, females experienced more negative health effects than males.

Based on these findings, it is important for researchers to disaggregate health data on Latino/a immigrants by country of origin, gender, documentation status, race, neighborhood, and generational status. Future research should measure multiple sources of heterogeneity to facilitate disaggregation; use intersectional lens and lifecourse models to identify who is affected by immigrant health declines, how they are affected, and when those effects emerge; and focus contemporary comparative research on differences in Latino/a health including migrant versus non-migrant, intra-ethnic/country of origin, and documentation status differences.

Asian American Quality of Life

Yuri Jang, University of Southern California

The Asian American population grew approximately 43 percent from 2000 to 2010. The “model minority” myth suggests that this population is well-educated, healthy, self-sufficient, and problem-free. However, this myth is influenced by sampling artifacts of national surveys that are primarily provided in English and thus erect linguistic barriers to heterogeneous subpopulations. These subpopulations are often inadequate to properly study Asian Americans, because even among large population surveys, the portion of Asian Americans is relatively small. Research that captures a more representative population presents a different picture.

An example of a successful study of a large subset of the heterogeneous Asian American population is the Asian American Quality of Life (AAQoL) study, conducted in Texas in 2015. The project targeted self-identified Asian residents in Austin ages 18 years or older. Along with English, there were seven Asian language versions of the survey (traditional Chinese, simplified Chinese, Korean, Vietnamese, Hindi, Gujarati, and Tagalog). Research personnel shared the same culture and language as the target population, and residents were identified by leveraging community partnerships.

Results of this survey overturned previous findings about Asian Americans. For example, the AAQoL found disparate levels of unmet medical needs among Asian Americans, ranging from 5.3 percent of Asian Indians to 17.1 percent of Vietnamese (compared to previously low findings of unmet needs among Asian Americans as a whole). Jang found that populations with lower levels of English proficiency had higher levels of unmet medical needs. Among minority populations, acculturation (including English proficiency) is a critical factor that determines health, wellbeing, and access to resources among immigrant populations. Acculturation should be studied in conjunction with acculturative stress. Other factors for researchers to consider include social networks, family solidarity, ethnic identity, and community social cohesion.

Discussion

Effect of Return Migration on Immigrant Health Studies

Some migrants to the United States ultimately return to their country of origin. Evidence has shown that individuals from the Caribbean are more likely to return to their country of origin than immigrants from Sub-Saharan Africa. Estimates of immigrant health do not account for these individuals, and researchers are encouraged to investigate their health.

Measuring Heterogeneity in Latino/a Subpopulations

NIA's large cohort studies, such as HRS and MIDUS, do not collect extensive data for immigrants. Further, any data collected on immigrants (e.g., country of origin) is largely unstandardized. Funding bodies should standardize data collection to allow disaggregation of subpopulations. The role of theory (i.e., the research community's approach to studying immigrants) is also important in deciding which data can shed light on transnational social ties.

Approaches to examining the wide heterogeneity among immigrants should acknowledge to the migration of individuals from the U.S. Virgin Islands and Puerto Rico. These individuals often have different reasons for migrating to the mainland and provide different perspectives on issues such as social mobility and health risks. However, researchers interested in researching Latino/a populations must consider when and how it is most appropriate to include Latino/a immigrants in their studies.

Benefits of Retaining Native Culture

Although lack of acculturation is correlated with negative health outcomes, *full* acculturation may also not be ideal for immigrant health. A study of Asian Americans revealed that persons well-versed in both cultures were the healthiest both mentally and physically. Individuals who are marginalized from both cultures are at highest risk for poor physical and mental health outcomes. In other studies, researchers have moved away from a unidimensional perspective on acculturation and toward a multidimensional model. A recent paper found that factors such as discrimination and family conflict predict acculturation profiles, which suggests that contextual factors should be considered in studies of acculturation effects.

Studying the health of immigrants' children may provide deeper insights into health disparities. Although first-generation immigrants have better health profiles than their native-born counterparts, the children of well-educated Black immigrant mothers are more likely to die in their first year of life than any of the least educated native ethnic groups. Despite the cultural factors and selectivity discussed, some evidence suggests that exposure to U.S. context has detrimental health effects on Blacks across generations.

Collecting Data on Immigrants

Researchers need better measures to perform intersectional work, and the existing framework of national studies are likely not up to the task. For example, that lack of data makes it difficult to estimate how much the "healthy immigrant" effect accounts for improved life expectancy in the Black population in the United States (although one estimate suggests the effect accounts for an entire year in that improvement). Approaches that collect data at the state and local

levels and address language barriers will help to answer health disparity questions. Recently the Census has started to contact a small number of non-English speaking populations, which is a step in the right direction.

Appendix 1. Meeting Agenda

Committee on Population Semi-Annual (Virtual) Meeting

May 18-19, 2020

(VIRTUAL) SEMINAR ON PERSISTENT AND LARGE RACIAL/ETHNIC DISPARITIES: BEYOND THE ROLE OF SOCIOECONOMIC STATUS (SES)

- | | |
|------------------------|--|
| 12:45 – 1:00 pm | Welcome and Introductions; Goals for the Seminar <ul style="list-style-type: none">- Frank Bandiera, National Institute on Aging |
| 1:00 – 1:45 pm | Session 1: Overview of the Issues: Race/Ethnicity, Moving Beyond SES, and U.S. Health Disparities <ul style="list-style-type: none">- Nancy Krieger (Harvard University) |
| 1:45 – 2:45 pm | Session 2: Lifecourse Stress, Discrimination, and Other Exposures <ul style="list-style-type: none">- Margaret Hicken (University of Michigan)- Sharelle Barber (Drexel) |
| 2:45 – 3:00 pm | BREAK |
| 3:00 – 4:00 pm | Session 3: Intergenerational Mobility and Racial/Ethnic Health Disparities <ul style="list-style-type: none">- Lauren Gaydosh (Vanderbilt University)- Jenjira Yahirun (Bowling Green) |
| 4:00 – 5:15 pm | Session 4: Intergenerational mobility and immigration, Context of Reception, and Racial/Ethnic Health Disparities <ul style="list-style-type: none">- Yuri Jang (USC)- Tod Hamilton (Princeton)- Carmella Alcantara (Columbia University) – |
| 5:15 pm | Adjournment |

Appendix 2. List of Participants

Presenters

Carmela Alcántara, Columbia University
Sharelle Barber, Drexel University
Lauren Gaydos, Vanderbilt University
Tod G. Hamilton, Princeton University
Margaret Hicken, University of Michigan
Yuri Jang, University of Southern California
Nancy Krieger, Harvard University
Jenjira Yahirun, Bowling Green State University

National Institute on Aging

Lisbeth Nielsen, Director, Division of Behavioral and Social Research (BSR)
Frank Bandiera, Health Scientist Administrator, BSR
Cerise Elliot, Program Director, Dementias of Aging Branch, Division of Neuroscience
Amelia Karraker, Health Scientist Administrator, BSR
Chandra Keller, Social Science Analyst, BSR
Georgeanne Patmios, Program Official, Population and Social Processes Branch, BSR
John Phillips, Chief, Population and Social Processes Branch, BSR

National Institute on Minority Health and Health Disparities

Dorothy Castille, Health Scientist Administrator, Division of Scientific Programs
Rina Das, Scientific Administrator, Division of Scientific Programs

Rebecca Lazeration, Rose Li and Associates, Inc. (Contractor)