

HISPANICS AND WORKSITE HEALTH PROMOTION: REVIEW OF THE PAST, DEMANDS FOR THE FUTURE

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ABSTRACT: During the last 15 years, reports, books, and published papers have demonstrated the positive health benefits of comprehensive health promotion and disease prevention interventions at the worksite. Although the progress made in worksite health promotion should not be understated, experts agree that it is time to step forward and address the new demands of the changing labor force. One area of intervention that needs to be more aggressively addressed is that of minority populations. Because work force projections show the high participation rate that Hispanics will have in the future labor force, the Hispanic population should be one of the targets of worksite health promotion. This paper reviews how employee health promotion programs have addressed Hispanic workers in the past and establishes directions for the future.

INTRODUCTION

Since 1980, a number of reports and published papers have demonstrated the positive health benefits of comprehensive health promotion and disease prevention interventions at the worksite¹. The recognition by Congress in 1946 of the importance of maintaining a healthy and fit Federal work force stimulated the establishment of services to promote and maintain the physical and mental fitness of employees. With leadership from the President's Council on Physical Fitness and Sports and the U.S. Office of Personnel Management, combined with input from other public agencies and business associations, funds were allocated to expand programs from basic screening and health risk assessment to more comprehensive activities, including health education programs and on-site facili-

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ties.² The interest in health promotion and disease prevention programs in private business and industry continued to escalate in conjunction with the self-care and wellness movement observed in the 70s. Since then, the wide variety of employee health promotion programs has been an important tool for communities interested in improving the wellness of their residents. Data from the two national surveys of worksite health promotion activities show that the percentage of private worksites with fifty or more employees offering some form of health promotion activity increased from 66% in 1985 to 81% in 1992.^{3,4} In the federal sector, the Federal Employee Worksite (FEW) Survey, conducted in 1989 among agencies with ongoing health promotion programs, indicated that 75% of employees participated in at least one agency-sponsored activity.⁵ Furthermore, a survey conducted in 1991 in midwestern U.S. cities compared health promotion programs offered by community providers, and found that the worksite provided about 40% of all health promotion programs offered to adults.⁶

The results of employee surveys indicate that employees believe programs are important and that health-related activities should be offered at the worksite.^{3,4,5} Statistics also confirm that well planned programs are cost-effective and save companies money.^{2,7} In addition, it has been demonstrated that the presence of health promotion and disease prevention programs at the worksite provides the benefit of attracting and retaining key personnel, decreasing absenteeism, improving morale, increasing productivity, reducing job turnover, improving the public image of the company, and promoting greater allegiance to the company by employees. All of this translates into an increase in the profits of an organization and often into benefits to the individual, such as improved lifestyle, greater happiness, and reduced risk of morbidity and mortality.⁸

Although the progress made in worksite health promotion should not be understated, experts agree that it is time to step forward and address the new demands of the changing labor force. Most specialists believe that secondary and tertiary prevention are areas that need to be developed in employee health promotion programs in order to complement and reinforce medical services provided by non-corporate physicians.⁹ In addition, such development will increase the cost-effectiveness of employee interventions, given the higher costs associated with the populations served by secondary and tertiary prevention programs.

Another area of intervention that needs to be more aggressively addressed by employee health promotion programs is that of minority populations. A lack of statistics on ethnic groups and minimal representation of minorities in the health profession have been common barriers to identifying and addressing the specific needs of different racial/ethnic

populations. Worksite health promotion programs have been tailored to fit occupational categories in which minorities are underrepresented. They therefore fail to properly address the increasingly multicultural reality of our labor force.^{1,9} Although participation of minority employees has not been denied, barriers have been difficult to remove.

Change is necessary, in view of the fact that African-Americans, Hispanics, Asian-Americans, Pacific Islanders, Native-Americans, and Eskimos will make up 28.4% of the U.S. population by the year 2000.¹⁰ Their contribution to the labor force is significant, especially in areas where there is a large concentration of one particular group. Multicultural approaches represent a challenge for employee health promotion programs. However, they are necessary given that people from different cultural backgrounds not only may differ in their health needs, but also in their views of wellness and prevention, their life experience and perspectives, and in their communication systems. One of the groups that can benefit from appropriate worksite health promotion programs is the Hispanic population. Hispanics have always played an important role in the U.S. labor force and their contribution to the development and progress of this nation will continue to increase.

HISPANICS IN THE LABOR FORCE

According to the most recent projections from the Census Bureau, for the first time ever, more Hispanics than whites are contributing to the growth of the U.S. population. The report estimates the number of Hispanics in the U.S. today to be 26.6 million (10.2% of the total U.S. population). This number will increase to more than 80 million by the year 2050. High fertility rates and increased legal immigration will be responsible for 90 % of this growth.¹⁰ Persons of Hispanic origin will comprise a substantially larger share of the total population in the near future: in the West the proportion of Hispanics will increase from 20% in 1993 to 29% in 2020; in the South, from 9% to 14%; in the Northeast, from 8% to 12%; and in the Midwest, from 3% to 6%.¹¹

The growth of the Hispanic community is having an even greater impact on the U.S. labor force than on the overall population. In 1992, Hispanics made up 8.0 % of the labor force (10.1 million workers), but some 7 million Hispanics are expected to enter the labor force within the next ten years. With a projected annual growth of 3.9%, the number of Hispanic workers will increase to 16.6 million by the year 2005 to make up 11% of the labor force.¹² The Hispanic population is proportionately very

young, and it will supply the labor force left behind by baby boomers. Women of Hispanic origin will catch up with what once was a rapid job participation increase for white non-Hispanic women. Hispanic professionals will find new opportunities due to the interests of U.S. companies in Latin America. All of these factors help explain why the Hispanic labor force is projected to expand by 60% by the year 2000, and why their share of the overall growth of the labor force will be more than 26% by that time.¹³

Besides Hispanic-Americans, Hispanic immigrants are also an important subset of the U.S. Hispanic population and contribute substantially to the total labor force. It has been estimated that about 36.2% of the net immigration projected to arrive in the United States between 1993 and 2005 will consist of Hispanics.¹⁰ Although many immigrants lack work experience in this country and face cultural and language problems, Hispanic immigrants exhibit considerable strength in relation to family, work ethic, and healthy lifestyles. As they adapt their skills to the new working environment and gain education, wages, employment tenure, and occupational mobility, they begin to approximate native-worker levels, and become more competitive in the work market.¹⁴

Another important subgroup is that of Hispanic migrant farmworkers. They account for 100% of the total of migrant farmworkers in the South; 90% in the Midwest; 80% in the East; and more than 50% in California, Nevada and Arizona. The number of migrant workers lies somewhere between 3 and 5 million.¹⁵

Hispanics are overrepresented in low, blue-collar occupations, and underrepresented in white-collar occupations. Data from the 1990 Equal Employment Opportunity File shows that Hispanics make up less than 23% of managerial/professional or technical/sales workers.¹⁶ Occupational mobility and subgroup variations are also worthy of mention. During the 80s, Mexican men and women did not have clear occupational gains, but Cuban men and women experienced an improvement in their occupational distribution. Puerto Rican women improved by moving into managerial professional occupations, but Puerto Rican men showed signs of occupational loss.¹⁷

HISPANICS AND EMPLOYEE HEALTH PROMOTION PROGRAMS

It has been reported that Hispanics have low rates of participation in worksite health promotion programs.¹⁸ Nevertheless, few researchers have investigated the response of Hispanic workers to employee health

promotion activities. A review of the literature reveals that programs have not evaluated the impact of intervention among Hispanic workers, nor have they developed comprehensive efforts to overcome the cultural and linguistic differences faced by many Hispanic workers. In addition, national initiatives to gather data on employee health promotion have not been aimed at including information about ethnic/racial workers, or have failed to properly address the issue. Therefore, opportunities to evaluate the impact of worksite health promotion programs among Hispanics and other racial/ethnic employees have been lost.

The objectives of the 1985 National Survey of Worksite Health Promotion Activities were to: (1) determine the nature and extent of worksite health promotion activities on worksites of 50 or more employees, (2) determine what employers perceived as the direct and indirect benefits of their efforts to prevent disease and promote health, and (3) monitor progress toward the worksite health promotion goals set forth in the *1990 Health Objectives for the Nation*.³ Although results clearly show that worksite health promotion activities are an accepted component of work in the United States, the survey failed to address the issue of program participants and demographic distribution. The 1992 National Survey was designed around the following objectives: (1) to describe characteristics of worksite health promotion activities in the private sector, (2) to measure the level of change in worksite health promotion activities since 1985, and track several of the worksite-related objectives in *Healthy People 2000*, (3) to compare worksite health promotion activities across industries and by worksite size, and (4) to describe aspects of worksite health promotion administration, evaluation, and benefits.⁴ While the survey was useful for determining the growth of worksite health promotion activities and other aspects of such programs,¹⁹ no attempt was made to gather demographic data, including ethnicity.

The goal of a third landmark survey of worksite health promotion activities, conducted in 1989 under the Federal Employee Worksite Project, was to assess the design, organization, and implementation of federal worksites with health promotion programs.⁵ The survey was aimed at exploring sociodemographic characteristics of participants, and it included questions concerning such factors as age, gender, race, employment status, salary, etc. Nevertheless, the majority of agencies used the term "minority" to report the make up of their workforce without distinguishing between different racial/ethnic groups. In addition, the surveyed workforce was mainly Caucasian, and more than 90% of the employees were in professional, technical/clerical and administrative/management positions,²⁰ leaving Hispanics and other groups underrepresented.

Worksite health promotion activities have been credited as important contributors to the favorable trends in some of the health promotion priority areas observed in the mid-decade review of the *Healthy People 2000* objectives.²¹ Nevertheless, particular problems remain for minority populations. Business leaders, unions, and employee benefits experts are included in the *Healthy People 2000* objectives for delivering and financing preventive health services. They are invited to promote culturally sensitive workplace programs of risk reduction, early detection, and prevention education. This is a significant opportunity, since ethnic groups have been more difficult to reach through traditional medical care and public health programs. The workplace has proven to be an ideal setting for program development, implementation, and evaluation because it offers greater access to adults in comparison to other community programs, provides a naturally supportive environment, can deliver preventive services at lower costs, and facilitates the development of more comprehensive programs.⁸

HEALTH STATUS OF HISPANICS

The health status of Hispanics is still imprecisely known and insufficiently analyzed. In 1992, the U.S. General Accounting Office recognized that there was no available comprehensive review of morbidity and mortality trends for different Hispanic subgroups.²² Contradictions, therefore, still exist. For example, although national studies have concluded that Hispanic-Americans in general have a life expectancy at birth and mortality trends that are close to or even more favorable than that of non-Hispanic whites,²³ state and local data indicate that there are significant differences. In Arizona, for example, data from 1991 show that white non-Hispanics live an average of 13 years longer than Hispanics.²⁴

Contradictions are not exclusive to mortality trends: they are seen in data related to risk factors, morbidity, and behavior. According to some studies, risk factors for Hispanics are similar to those for the general population when adjusting for variables. A recent study from California comparing health-risk related factors in Hispanics and whites found no significant differences between both groups for blood pressure indicators, caloric intake, total cholesterol, alcohol intake, or physical activity, after controlling for potential confounding sociodemographic variables. Body mass index and HDL cholesterol were the only two variables for which Hispanics had a higher level of risk.²⁵ Nevertheless, other studies have demonstrated that Hispanics have a higher prevalence of overweight than non-Hispanic whites;^{26,27} that Mexican-Americans have higher blood pressure than non-Hispanic whites;²⁸

and that Hispanic 8th to 10th graders who drink alcohol drink more than their white and African-American counterparts.^{29,30} Subgroup differences, which are crucial when evaluating mortality and risk factors among Hispanic populations, often contribute to some of the contradictions observed in the statistics. For example, NID diabetes and obesity are more prevalent among Mexican-Americans,³¹ colorectal cancer mortality is higher for Puerto Ricans born in the States than for island-born residents in New York City,³² and cigarette smoking has been found to be more prevalent among Cubans and Puerto Ricans than among Mexican-Americans.³³

Despite the lack of reliable data, the 1985 Report of the Secretary's Task Force on Black and Minority Health clearly states that the six priority health problems among minorities, including Hispanics, are preventable. These include: cancer, cardiovascular disease and stroke, chemical dependency, diabetes, homicide and accidents, and infant mortality.³⁴ AIDS was added to the list in 1986 by the Office of Minority Health.³⁵ Tuberculosis and female overweight are also prevalent health problems that need to be addressed among Hispanic groups.²¹ Since all of these conditions are affected by lifestyle and environment, appropriately developed employee health programs have the potential of being useful tools for improving the well-being of Hispanic communities and for facilitating the achievement of *Healthy People 2000* objectives.

HEALTH PROMOTION PROGRAMS FOR HISPANIC WORKERS

Since more Hispanics are entering the labor force, and more medium and large businesses support health promotion activities, the contribution of employee health promotion programs to the improvement of the health status of Hispanic communities could be considerable. The degree of sophistication and the variety of components of appropriate and comprehensive programs seem right on target in terms of meeting the health needs of Hispanics for several reasons. First, most programs include health risk analyses and personnel health profiles that could serve as sources of data for Hispanic subgroups concentrated in geographic areas and occupational categories. The lack of data on specific Hispanic health issues at local and regional levels is one of the main concerns in disease prevention and health promotion among Hispanics.³⁶ Second, the workplace is an ideal setting for developing culturally appropriate theory based interventions that can be better followed and evaluated at three levels: process, impact, and outcome. This is an attractive field of study that has recently been included on the Hispanic research agenda.³⁶ Third, most

employee health promotion programs offer preventive services, health or physical exams, and health education and information.¹⁹ Such services are essential in programs targeting Hispanic communities, given the lack of access to health services and management of chronic conditions prevalent among Hispanic adults.³⁷ Finally, the workplace is an ideal setting for overcoming many of the barriers faced by Hispanics when dealing with their health care. It has been reported that, because many Hispanics feel estranged from the US health care system, they fail to seek preventive services.³⁸ The worksite offers a more comfortable environment for Hispanics than many health institutions. In addition, it can overcome barriers related to transportation, personal interaction, or the involvement of friends, which represent important considerations when dealing with the provision of services to Hispanics.

Worksite programs targeting Hispanics, or aimed at including Hispanic workers, should heed the following recommendations:

- 1) Do not adapt interventions. Develop programs that are culturally and linguistically sensitive to Hispanic populations. This means including Hispanic researchers in the program planning, having bilingual/bicultural facilitators, developing educational modules that cover particular health needs and behavioral practices, providing linguistically appropriate materials, etc.

- 2) Establish goals and objectives that target the specific needs of the Hispanic workers to be served. The term Hispanic encompasses various subgroups with different national origins, behavioral practices, risk factors, and health needs. Therefore, in the planning process there should be needs assessments that include demographic characteristics and break the overall target group down into different ethnic/racial groups and Hispanic subgroups. In addition, focus groups should be organized with workers to explore perceived needs, and cost concerns should be determined for each group.

- 3) In order to facilitate behavioral changes and positive outcomes, develop programs that include three levels of intervention (awareness, lifestyle change, and supportive environment) aimed to affect knowledge, attitude, and skills. This means more than simply health education, and involves including worker associations and Hispanic leaders, finding support at managerial level, programming family activities, and working with Hispanic community organizations.

- 4) Remember that variability is one of the most intrinsic characteristics of the Hispanic population. It is common to find, within the same group, people with different levels of acculturation, language skills, and so on. This can be especially significant in large corporations. Part of the

success of the program may depend on the ability to accommodate everyone, to provide bilingual activities, and to consider different levels of implementation.

5) Always plan three levels of evaluation (process, impact, and outcome), and consider demographic characteristics when evaluating the program. When the target population includes more than one ethnic/racial group, it is important to establish the effect of the program in each group independently.

Worksite programs will improve the health status of Hispanics by providing services and implementing education and promotion interventions. At the same time, well planned programs will contribute to the collection of data and the evaluation of specific strategies for Hispanic populations.

Health promotion has been defined as an art. It is a challenging art, since it deals with human behavior, which in many cases, is highly unpredictable. Diversity is just another element that we must overcome to achieve the mission of health educators, which is to facilitate the participation of everyone by removing barriers, and assuring accessibility. Hispanic participation in the labor force does not ensure that they receive adequate medical care, preventive services, and health information. It is the responsibility of health professionals to deliver such services, and employee health promotion programs constitute an excellent opportunity to improve the health of Hispanic communities.

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