Using World Health Organization data for 2001 and 2015, Chen et al analyzed all premature deaths (defined as those occurring in individuals aged 20-64 years) among US Latino, African American, and white populations and Puerto Rican and 12 other Latin American populations. Their major findings were that US Latina women had the lowest premature mortality rate of all populations studied and that mortality among US Latino men was lower than that among all populations except for Peruvian individuals. Their other significant finding—specifically, that US Latino populations have lower mortality rates than US white populations—adds to the literature documenting the Latino mortality paradox.

The study by Chen et al is important because their analysis of individuals in Latin America represents the source population of US Latino groups. Therefore, the mortality rates for these groups may approximate the outcomes for US Latino groups had they not migrated. This analysis contributes to our understanding of Latino health in the countries of origin and in the United States. Their findings suggest that all-cause mortality among US Latino populations may be driven by protective factors possessed by the immigrant generation.

In a meta-analysis of the Latino mortality paradox, Ruiz et al concluded, “It might be time to move beyond the question of the existence of the Hispanic mortality paradox and onto investigations into the causes of such resilience.” They suggested that future research should explore risk and resilience mechanisms and potentially complex interaction patterns among social and cultural factors, such as socioeconomic status and acculturation. Along these lines, it should be noted that the analysis of Chen et al, which combined US Latino populations into 1 large category, obscures health differences among the groups. The Hispanic Community Health Study/Study of Latinos revealed differences in health among the various Latino groups. Puerto Rican individuals, in particular, had high rates of many cardiovascular risk factors compared with others groups. Although there is growing recognition of differing health patterns and profiles among the various Latino groups, to date, there are almost no data on the health or health behaviors of Salvadoran individuals and very few studies of Dominican individuals, who constitute the fourth and fifth largest Latino groups, respectively, in the United States. Moreover, there are differences between US-born and immigrant Latino populations on a variety of health indicators. For example, compared with those who are born outside the United States, US-born Latino populations have higher rates of obesity, hypertension, smoking, heart disease, and cancer. Thus, despite the intriguing findings of Chen et al, their study raises questions about potential health risks for Latino groups both in the United States and in Latin America. For example, obesity rates are increasing in Latin America, and the US environment is particularly obesogenic, with exposures that promote obesity-related behaviors such as higher caloric intake and/or sedentary behavior.

As Chen et al noted, over the past several years, the proportion of immigrant Latino individuals in the United States (ie, those born outside the United States) has been decreasing. Currently, approximately one-third of Latino individuals are immigrants. The finding by Chen and colleagues that premature death rates are lower in various Latin American countries than among US white populations raises an interesting question of whether there is a Latin American paradox.

The Latin American paradox requires an exploration of potential broad social determinants of health that might explain some of the patterns observed by Chen et al. For example, their analysis indicates that in 2015, Belize had the highest all-cause mortality rate compared with other populations. This was driven primarily by external causes (eg, accidental death). Belizean high
unemployment rates and increased involvement with the Central and South American drug trade have contributed to sociopolitical instability. Because of an increase in gang violence and its small population size, Belize ranks among the top 10 countries in the world for homicides. In this sense, Belize aligns with the trend of regional violence and increased poverty present in Central America, specifically in Guatemala and Honduras. Although Chen et al1 did not include Honduras and Guatemala in their analysis because of missing data, there has been an increase in migration within Central America, and similar gang-related activity and deaths have been reported in those countries. In fact, Belize, Honduras, and Venezuela lead the world with the highest homicide rates per 100 000 inhabitants. Furthermore, 28% of Belizean mortality is due to injuries and external causes, and homicide is one of the leading causes of death among men specifically.

Chen et al1 found that in contrast to Belize, Peru had the lowest mortality rates of all populations examined. Social determinants may also partially explain these findings. In part because of Peruvian President Alberto Fujimori’s resignation in 2000 and the instatement of a new regime, Peru’s poverty and unemployment rates have decreased dramatically in the last decade. Peru is now one of the most robust economies in Latin America. Peru’s major causes of premature death are communicable diseases and cardiovascular disease. Nevertheless, Peruvian poverty rates and low educational achievements persist. This may be tied to the more than 2 million Peruvians who have emigrated out of the country over the last decade, primarily to the United States, Spain, and Argentina.

Migration is an also increasingly transnational phenomenon. Migrant networks connect populations across countries and serve as conduits through which financial remittances and other cultural influences affect migrants’ sending communities. There is evidence that migration networks are associated with increased body mass index and obesity within Mexico. Therefore, robustness of networks may serve as both risk and protective factors. In Latin America, circular migration patterns often are sparked by civil, political, and economic unrest. Because of missing data, Chen et al1 excluded many of the countries experiencing this type of unrest, mainly El Salvador, Guatemala, and Honduras. Collectively known as the Northern Triangle, these 3 countries in Latin America experience extremely poor economic conditions and increased violence, which then spark risky migratory patterns, especially among children. Equally relevant are countries like Venezuela and Bolivia, which were also excluded because of missing data. It is somewhat difficult to speak to an overall Latin American paradox without the inclusion of these countries.

Despite these limitations, as well as those of the population comparisons in the analyses by Chen et al1 (eg, between-country variation in health care and social and political conditions), the data suggest possible cultural, lifestyle, or behavioral explanations (eg, smoking) for the lower premature mortality rate among US Latino populations. These data underscore the need for more systematic explorations of whether cultural and other social or behavioral factors, such as health-promoting practices, contribute to Latino health. For example, it would be informative to explore population differences in resilience or health-promoting factors (eg, healthful diets or supportive networks) and risk factors (eg, smoking or drug use), as well as associations between acculturation and health.

To continue to move forward a research and practice agenda focusing on Latino health in the United States and Latin America, it will be important to place more emphasis on the heterogeneity of the Latino population. Other areas of focus include a closer look at the economic, political, social, and cultural factors in the United States and Latin America that are associated with immigration patterns and mortality rates.

ARTICLE INFORMATION
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