CULTURAL INJUSTICE AND HUMAN HEALTH

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This paper seeks to address the issues of cultural injustice and human health. Health is the fundamental issue in all human societies and the key to well-being and happiness. World organizations are involved in health promotions through the prevention of disease and the creation of primary care agencies. More and more specialists in health care have come to recognize the importance of the social sciences in promoting healthy practices through the use of public education and the media. Successful approaches to health care must be based on accurate cross-cultural understandings of what is universal and what is culture-bound in illness. The involvement of indigenous communities is seen as important in order to achieve successful outcomes for example in the creation of Aboriginal Health Centers in Australia (Larsen, 1979a, 1979b, 1980).

The very conceptions of health have been altered in response to advances in social science. Health is now considered to be a human state that is more than the absence of disease. Health has become conceptually complex and covers all dimensions of life and the mental and social well-being implied in the term "quality of life". Subjective well-being takes into account all factors from a person's psychological life space and the cultural surroundings required for optimal human development. In fact an interdisciplinary approach is essential in order to reduce the health disparities that are primarily related to socio-economic deficits so obvious in the world (Anderson, 2009).

Cross-cultural psychology is making important contributions, particularly by providing an understanding of the cultural framework for both physical and mental health services. In fact physical health and mental healthcare are interdependent, and must be understood within the framework of both cultural knowledge and cross-cultural comparative findings. In particular psychology has produced helpful knowledge in salient areas including cognition, but also in understandings of emotional, behavioral and social aspects of life considered essential information for culturally based practices and individual therapy. Cross-cultural researchers recognize the need for cultural sensitivity in delivering empirically verified treatment in a still heterogeneous world.

The need for cultural and cross-cultural knowledge can be ascertained by the large scale differences between various cultural groups in physical and mental health (Gurung, 2010). Cultural values produce different conceptions about the nature of health and illness and what treatment strategies will have optimal outcomes. Not all cultural groups are on a level playing field and being poor is implicated in the etiology of most infectious and chronic disorders in the world. Low socio-economic status is linked consistently to health related death rates and produces health related disadvantages from birth throughout life.

The injustice of health disparities in the world.

Health disparities connected to socio-economic status occur all over the world. In the U.S., African Americans suffer especially from appalling infant mortality rates that are twice as high as European Americans. Likewise deaths from heart disease are 40% higher among African Americans compared to descendants of Europeans. The most salient statistic that reflects health is life expectancy,

and here there is a difference of 35 years between some ethnic groups in the U.S. (U.S. Department of Health and Human Services, 2009; Murray, Kulkarni, Michaud, Tomijima, Bulzacchelli, Iandiorio, & Ezzati, 2006). Nearly one in two people in the U.S will suffer from a major mental disorder in their lifetimes, and millions of sufferers do not receive any care whatsoever, and this is in the richest country in the world. While mental illness strikes people in all social classes the poor are disproportionately represented. At any time about one in six people living at or below the poverty line in the U.S. suffer from a severe mental health problem. From an economic point of view inadequate mental health care cost billions of dollars to the U.S economy each year (Editors, 2012).

It is not difficult to understand that people living in poverty are also more depressed as compared to more well of people (Pratt & Brody, 2008). Parallel socioeconomic disparity occurs also between poor and wealthy countries. In rich countries the well off have access to the latest in health care that is too costly for poor countries to acquire. For people who believe that good health and effective health care is a basic human right the socioeconomic disparity that drives health outcomes within and between countries appear as a grand injustice. While the effect of socioeconomic disparity in health is supported by available statistics there are notable differences. Cuba, a relative economically poor country, has poured a major portion of their meager resources into health care and education making both accessible to all citizens. A major result is a lower birth death rate in Cuba compared to the U.S. a much richer neighbor, and Cuban doctors serve all over the world in poor countries trying to bridge the disparity caused by poverty like for example in Haiti and Venezuela.

Socio-economic disparities and well-being.

Culture is affected by the ecological environment, but at the same time culture also changes the environment in ways that affect both physical and mental health. Population increases in developing nations have created many challenges to provide adequate nutrition to people and affects infant survival rates. The population of the world is increasing, especially in developing countries, stressing the world's resources, economic relations between rich and poor countries and ultimately socio-economic stability. One reason for the larger fertility rate in developing nations is the inability of these societies to provide social security for people reaching old age, and the need to have surviving children provide the essential psychological and material support. Cultural values play an important role as women who are socialized with traditional gender values tend to have larger families which perpetuate the limited social roles of females in traditional cultures.

Population increases are not benign as they are typically also related to industrialization of society, larger cities and socioeconomic disparity between rich and poor. In terms of physical health the stress caused by industrialization includes hypertension and many associated outcomes like heart disease. Whether the result of industrialization is positive or negative appear directly related to wealth disparity. Where there is a relative equitable distribution of wealth and health related resources the outcome is better for overall health and increased longevity of the population. The key is not the overall wealth of a nation, but the degree to which the wealth is distributed in egalitarian or disparate ways. For example in the U.S. mortality rates vary between the states directly as a function of the inequality of income. The injustice is also present between nations varying in wealth, and the differences in health related expenditures differ widely between countries with people needing services the most getting the least.

The economically disadvantaged whether within or between countries suffer more malnutrition. A major concern is the relationship between malnutrition and psychological functioning. This is an issue of catastrophic proportions and likely to get worse with a growing world population. In developing countries a full 46 percent of children suffer from malnutrition that has very negative consequences on

physical and psychological development (UNICEF, 1996). Malnutrition is a complex phenomenon involving cultural practice, limitations of the environment, and economic and social organization. Nevertheless there is sufficient food in the world as a whole if political will and organization would permit it to reach those that suffer from malnutrition (Barba, Guthrie, & Guthrie, 1982). Psychologically the greatest impact of malnutrition is on cognitive development . The earliest years are of greatest significance for intellectual development. Children who need hospitalization to recover from malnutrition or suffer malnutrition that persist over a period of months in the first two years of life suffer a severe decline in intellectual functioning of about 10 IQ points. There is some evidence that even milder forms of malnutrition may affect intelligence and increase infant mortality. Not having sufficient nutrition also causes passivity in children and removes the normal intellectual stimulation that children experience when well nourished through exploration activities.

Typically, malnutrition does not occur in isolation, but is present in conjunction with other adverse environmental conditions including exposure to disease, unhygienic conditions, and substandard housing. These are the effects of unjust economic distribution both within and also between cultures. For example traditional cultures with many adverse environmental conditions frequently produce additional stress by the challenges of large families and dysfunctional family life. It is clear that the adverse affects of malnutrition goes far beyond mere intellectual functioning as it may for example contribute to an acceptance of the status quo for lack of individual and social energy and innovation. Given the critical period of early childhood the general rule is that the earlier the nutrition intervention in the child's life the better. International intervention includes emergency food, but also could provide skills to the community that optimizes child development.

Mental health among ethnic minorities: Injustice in the United States.

Native Americans have inherited poverty and discrimination as the outcome of cultural genocide carried out initially by European invaders. The disruptions of the traditional economic lives of Native Americans and resettlement into reservations that are socio-economically dysfunctional have created stress, poverty and alcoholism. Compared to other ethnic groups Native Americans suffer the highest level of anxiety based disorders (Smith, Stinson, & Dawson, 2006). It is easy to conceive that the marginalization of Native American communities translate into fundamental mental health disorders including depression. The social and economic base for a healthy life is missing from many Native American communities that in turn produce mental ill health, and destroys hope for the future (Organista, Organista, & Kurasaki, 2003).

African Americans brought to the U.S. as slaves centuries ago is another group suffering from historical discrimination and cultural genocide. That humiliating tradition and subsequent discrimination still affects Blacks psychologically with the principal heritage being poverty and social dysfunction. Research has shown that mental disorders are significantly higher among African Americans compared to European Americans. Again these results appear the direct outcome of poverty, inadequate physical and mental health services, and an economy that channels many young people into crime as the only utilitarian way to escape economic realities. The socio-economic disparities between European and African Americans are so high that rate differences in mental disorder cannot be unrelated. For example when socio-economic differences are controlled in research, the mental health differences between the two groups largely disappear with African Americans suffering similar rates of mental disorder as whites. However, these socioeconomic disparities remain today and African Americans suffer disproportionately much higher rates of Schizophrenia, depression, and anti-social personality disorders. Other studies also support the higher rate of bipolar disorders among African Americans (Smith et al., 2006).

Since Latin Americans constitute the fastest growing ethnic group in the U.S. there is a very large social and cultural base of support for individuals suffering stressful events. Members of some Latin groups integrate very readily into the broader society and do not suffer the socio-economic deprivations. There are however significant differences in health between various Latin groups that can be attributed to differences in socio-economic status, the experience with discrimination from the broader community and the cultural support available (Guarnaccia, Martinez, & Acosta, 2005). For example, to undermine Cuban society and encourage defections, the United States have treated Cuban immigrants preferentially with immediate socio-economic support and permanent residence, while discriminating against more needy groups like migrants arriving from Haiti. Cubans as a group have a relative high socio-economic status and are less likely to report symptoms of mental disorder.

Likewise Asian Americans typically have a strong cultural base; however there are significant differences in socio-economic status and mental disorders between different ethnic Asian groups. The Asian immigrant groups that suffer most from socio-economic disparities also report greater mental health related symptoms. Those living with poor socio-economic circumstances and/or have refugee status have higher rates of mental disorder. We can conclude that the differences in mental health between European Americans and other ethnic groups in the U.S. are primarily attributed to unfavorable socio-economic circumstances among the ethnic minorities.

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