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INTRO
Welcome to the Skin You're In Podcast, where we create a space to learn about health and social injustices rooted in racism. Through in-depth conversations with experts and everyday people, we explore the issues, potential solutions, and the effects those injustices have on individuals, families, and communities. Hello, and welcome to the Skin You're In Podcast. I'm your host, Thomas LaVeist, Dean and Weatherhead Presidential Chair in Health Equity at the Tulane University School of Public Health and Tropical Medicine and Principal Investigator for Partners for Advancing Health Equity.

And I'm honored today to be joined by our guest, Dr. Kyriakos Markides

0:00:54

Dr. LaVeist
He is currently the Annie and John Netsinger Distinguished Professor in Aging and professor at the School of Public and Population Health at the University of Texas Medical Branch in Galveston, Texas. He's also the editor of the Journal of Aging and Health, which he founded in 1989. He is the co-author of more than 400 publications, most of which are on aging and health issues in the Mexican-American population, as well as health equity and aging in general. Dr. Markides is credited with coining the term Hispanic epidemiological paradox, which is currently the leading theme in Hispanic health. Dr. Markides, thank you for taking the time to talk with us today.

Dr. Markides

Well, thank you for inviting me.

0:01:39

Dr. Markides
I look forward to our conversation. Yeah.

Dr. LaVeist

Well, first, how are you feeling today?

Dr. Markides

I am feeling good. It's nice to be with you. It's a nice day. It's not raining. It's been raining forever, but it's not raining and sunshine, at least for the morning. Yeah. So it's good to be with you.

0:01:51

Dr. LaVeist
So we both live in the Gulf South in hurricane-owned areas. Yeah.

Dr. Markides

And of course Thomas you know, I went to LSU, so I'm not very far. I was not very far from where you are now. Of course, New Orleans is a big part of my life and my graduate school. Anyway, moving west to San Antonio first and then to Galveston. It's, yeah, the Gulf Coast. It's a special person in many ways.

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Dr. LaVeist
Well, we'll try not to hold that LSU against you. Okay. Some of my best friends are, no, my counterpart, Dean Smith over at LSU, is a good friend, and we actually meet all the time and talk about public health. So, it's a pleasure to have the opportunity to talk to you about the work that you've done. Your work, I would say, has been foundational in the area of health equity. Talk to me about your background. You know, where did you grow up and how has that informed the work that you've been doing?

Dr. Markides

Well, you know, I was born and raised in Cyprus, you know, the island nation, sadly divided between Turkish and Greek origin. Cyprus used to be a British colony, if you know, until about 1960s there were gated dependence and France, who lived with majority Greek and minority Turkish, caused all kinds of issues. Inter-communal conflict, which was part of my growing up, and so on, but things were good.

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Dr. Markides
My background, I was kind of a middle-class family. My parents had a corner grocery store that did quite well in the 60s. I grew up in a really warm family, intact family, supportive family. And family that you know had enough faith in me to send me to the United States in 1968 to study and not many people did that from there, all the way to make their journey to the U.S. It was a major, major influence and of course I have to credit my parents, especially my mother, for thinking that I deserved better, I deserved a really good education, I deserved the best. And in 1968 I went to Bowling Green, Ohio, primarily because my cousin was there, my previous cousin, and of course 1968 was a very eventful year in this country, of course. It wasn't long ago after I got there, and Martin Luther King was assassinated in March and then in May, Bobby Kennedy, and then I guess the Chicago Convention later on in the summer and fall. And you know at first I had no idea what the hell was going on. I thought it was normal. You know, this is the United States, right? It's normal, 68, and of course people make movies now about 1968. It was a very special time.

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Dr. Markides
That was really my early career, undergraduate school, and the issues that went along. Kent

State came around 1970. March, of course, we were very much part of that. So I lived through the turmoil and the racial tension of the early years and which in some ways continue to today. There were riots all over the place. I worked for the summer, I worked in Plainfield, New Jersey as a car hub, summer of 68. And you know, and it was right after there was so much turmoil and then of course we have Nixon and then Watergate later on. And you know, I have lived the last 54 years in the United States, which is more than the majority of Americans. And I came from the outside. I have the outsider's perspective on the United States and on what was right and what was wrong. Things have changed, some for the better and some really for the worse. So, it's one of my, you asked about how my upbringing affected my work. Well, you know, I grew up in a familistic culture, right?

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Dr. Markides
Right? Mexican, Greek, Mediterranean Greek, Cypriot. Very familistic. And part of what attracted me maybe to the American, Mexican American population when I went to San Antonio, besides having no choice but to work with the population, because half of it in the city was Mexican American, was the familistic nature of the culture. And I saw how that actually influenced the well-being of older people. That's what we were actually interested in at the time, but really old people. And not that, you know, families solve all the problems. The population has a lot of issues. Poverty was one. We don't talk as much about discrimination as we talk about the African-American groups. But you know, there was a whole lot of discrimination in the Mexican-American community historically.

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Dr. Markides
What was good about San Antonio was like it was a kind of a Hispanic, Mexican-American community in many ways. So there was a lot of pride in being Mexican-American and being in San Antonio. But when you go back to the Rio Grande Valley and the issues there, there were so many and we can spend a long time discussing them. And the occupation of background population, the foreign background. And then of course the immigrant experience. And the immigrant experience, you know, there are positives and negatives. And then it has continued and continues till today. The immigration from Mexico and also increasingly from Central and South America is shaping up what the Hispanic population of the United States is doing now and what the aging of the population might in the future.

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Dr. Markides
And we can maybe talk about the future a little later. But anyway, yeah, that was my background. I was an undergraduate student in Ohio. And for many reasons, I went to Louisiana. One of them was weather. You know, it was really hard adjusting to, I went there in January. And it was hard adjusting to the cold weather. But going south was a good change at the time. And New Orleans was close by, and that was kind of unique.

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Dr. Markides
And the school was not the best, LSU, they won. Even the football team wasn't good in those days, but it was a good place for me. And I was treated very well. And I was able to get some really good training in demography and sociology, and which kind of earned me a position in the medical school in San Antonio, and gave me the opportunity to begin my career by initially doing a survey of the population, the Mexican-American population and Anglo population in the west side of San Antonio.

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Dr. Markides
And some of the early findings were kind of interesting in that we thought that what was really happening to the population, there was migration away from the west side of San Antonio where the population lived and to other places in the country. And there were signs of a decline in the family supports, and we wrote about that. And that kind of led to our thinking about the need to actually learn, not just from asking older people about their families and their upbringing as someone, but also asking their children and their grandchildren. We did a three-generation study in San Antonio back in the early 80s. That was really good. Yeah.

0:10:57

Dr. LaVeist
I'm sorry. Let me interrupt you just for a second.

Dr. Markides

Sure.

Dr. LaVeist

Before we get into the research, I did want to ask you a little bit more about your background. Sure. You said something that kind of piqued my interest, that as an immigrant, you have an outsider's perspective. And, you know, I'm the son of immigrants. I don't know if we've ever just talked about that. And so I know my mother immigrated from the Dominican Republic, my father from St. Martin, and so I'm the first generation born in the country.

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Dr. LaVeist
And my perspective on immigrants is that immigrants are not normal people. And I mean that as a compliment. Somebody who packs up everything they own and moves to another part of the planet and starts over, that's not a normal person. That's not an average person. Most people don't have the intestinal fortitude or whatever, industriousness, courage,

whatever term you want to use to do such a thing. So what was it about you that gave you the impetus to do something as unusual as pack up everything you own, moved to another country and start a new life?

Dr. Markides

Well, you know, I wasn't an immigrant, really. I was a student, a foreign student. I went to study and my initial intention was to go back. And for many reasons I was interested in things like economic development and social development and developing countries and issues related to that. Because Cyprus at the time was a developing country.

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Dr. Markides
Now it's really very developed. But back then, I was not really an immigrant. I became, I guess, an immigrant when I decided to stay. I got married, I went to graduate school and then stayed. But you're right about immigrants being special people. Most immigrants are voluntary immigrants, right? And they move because they want to improve their lives, which is a really good psychological factor that benefits them. And like you said, they're special people.

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Dr. Markides
They're people that have the background. They're healthy enough to move, and that's why the Hispanic paradox is part of the story. Immigrants are definitely special people. At the same time, we should not forget that immigrants face a lot of adjustment problems. There may be language-related, there may be cultural-related too. I felt that there were cultural issues in moving even a university environment, which is very liberal, very open-minded and accommodating. The culture was different. There was more individualistic, you know, and which kind of leads to this notion of equity, right?

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Dr. Markides
American individualism, which many people claim that, you know, that's what made America great, right? It's the individualism of the population, wanting to move forward, the frontier mentality and so on. Well, at the same time, which the individualism that emphasize equality of opportunity and not so much equity, okay? At that time, it was very much parts of something I noticed. I noticed that not soon after that, even being a 20-year-old when I came, that indeed this was a different place and it's going to take some adjusting to live here. And the way you adjust to that is as a student you concentrate on your studies primarily, and well, of course, being gone, I was able to fit in and meet people and so on.

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Dr. LaVeist
Well, you concentrated on your studies, but not exclusively. You said you got married, and is that what really led to you staying here in the country, in the United States?

Dr. Markides

Yeah, getting married in some ways was a good thing. It kind of insulates you from maybe the stressors of the larger society, in that you're sharing your life with a native U.S. born person. That definitely helped. I became acculturated. I became acculturated. To be honest with you, Thomas, I have never, ever to this day have been treated like an outsider.

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Dr. Markides
I've always been treated like somebody who contributed to the United States. I had some advantages. I was white, like most other people. I was educated. That's not the case with a lot of immigrants who come in and don't go to universities. They go to labor situations, agricultural communities in the United States, and they face a lot of discrimination in doing so. Their lives have gone what I would call significant turmoil and disadvantages. The cumulative disadvantage hypothesis, which has been applied to African-Americans primarily, but also to women, came out of women's studies, a lot of these intersectionality theories.

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Dr. Markides
So it can apply to immigrants, too. And we can actually come back to some of the papers that I wrote about that. But a lot of these immigrants, they seem to come in healthy, but they face a lot of stresses and disadvantages and so on that people coming as students do not necessarily. Yeah. Yeah.

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Dr. Markides
And of course, you're familiar with foreign students too, you know, in Tulane and other places. At Hopkins when you were there. They're, by and large, people who work very hard. They're special in some ways, too.

Dr. LaVeist

So let's talk about the work. You have quite a body of work, over 400 peer-reviewed publications. And that is simply incredible productivity for a scholar. Let's talk about one paper in particular, one that I think has really been seminal to the field, both in the social sciences and in public health.

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Dr. LaVeist
And this is the paper you published in 1986 in the journal Public Health Reports. The health of Hispanics in the Southwestern United States, an epidemiologic paradox. This coined the term and sort of created new knowledge that I think now we see as simply convention. Talk about what the findings were of that. What is the Hispanic paradox?

Dr. Markides

Well, the Hispanic paradox is that the Mexican-American, the Hispanic population overall is socioeconomically disadvantaged.

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Dr. Markides
And we know that socioeconomic conditions and status is definitely related to good health, right? We have myriads of studies supporting that. The studies on the Hispanic and Mexican-American population found that despite the poor socioeconomic conditions and status, the population has reasonably good health, as good as the non-Hispanic white, and even better with mortality statistics that began showing an advantage until 1990. And that's when people just began talking about the Hispanic paradox and we did too, and others. And so it is basically the reasonably good health of the population, especially as exhibiting mortality statistics despite poor socioeconomic conditions.

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Dr. LaVeist
So that's interesting. So in spite of the fact that the Mexican-American community that immigrated to the U.S. has a lower socioeconomic status than white Americans, in many cases they have better health statistics, at least in terms of mortality, and that's the paradox, that this group is doing better than you might expect. Is this all Hispanic populations or is it just Mexican Americans?

Dr. Markides

Primarily the Mexican Americans and the Central Americans. The Cubans were different in that they came with an advantaged status way back. There's some evidence with Puerto Ricans, but it’s not showing an advantage in Puerto Rico. The reason is that Puerto Ricans are not immigrants. The ones that moved to New York or Florida, they have no barriers to immigration. All they have to do is pick up an airplane and land in New York.

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Dr. Markides
They have no barriers. So therefore, they're not selected, okay? Mexican origin population are selected and the Central American population are selected because they have to pass exams, they have to cross the Rio Grande, which is a challenge, also it's a barrier. And the immigrants who want to improve their lives, like we said before. So there is, you know,

there is some evidence, if I may, Thomas, from the Mexican migration studies that Mexican families in Mexico, in sending communities, will pick the child that is most likely to be successful and send them to the United States because that person will be able to do well and send money back to the family. So there are a lot of reasons for migration selection of immigrants out of Mexico and out of Central America. And really out of countries, from other countries.

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Dr. Markides
The point at the time that Lizonda led us to that, developing that, was when we looked at mortality statistics primarily for the Mexican-American population of Texas and also California, they were not the best data. There were equal issues and holes. But they seem to point that the mortality of the population at the time, around 1980, over 40 years ago, was kind of similar to the non-Hispanic white population. And you know, there were a lot of people who said, wait, they were bad data. And they were bad data, causing the seeming advantages. So they were not real advantages. It was just bad data. And I wasn't convinced of that. We also studied infant mortality at the time in South Texas, and we found an advantage in infants. And subsequent work has supported that. And the infant mortality advantage was definitely related to migration selection.

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Dr. Markides
The mothers who immigrated to South Texas to have their babies or to live there, were healthy mothers that had healthy babies. So, it wasn't just the young middle-aged people that come in as healthy. So, I began thinking this is real, even though the data were not the best. And we, because of the infant mortality migration data, we thought maybe this migration selection applies to all people. So, all people coming in, at least voluntarily, as middle-aged or younger people than to be healthy people. And we suggested that hypothesis at the time. Along with, you know, we couldn't avoid the idea that people were writing, and there were probably minority people out of social work that were writing that, and they were pointing to the strengths of the family as being a factor in good health in the population.

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Dr. Markides
What was interesting about it, Thomas, is that the first few years, nobody paid attention to it. And, you know, it just didn't catch, it wasn't published in the American Journal of Public Health, which it should have been, published in Public Health Reports. But it got a lot of attention later, but not right away. And the reason was the American public health declined it because they thought it wasn't a real thing. Okay. But then other people found, started finding advantages, including mortality. So they came back to our paper to get theoretical support for their findings. And so the field developed and began pointing to immortality

advantage, not just immortality similar to the known Hispanic white, but immortality advantage. And people started wondering. The paper got a lot of attention.

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Dr. LaVeist
Let me ask, just out of self-interest, what about any research on the Dominican population.

Dr. Markides

Actually, the research of the Dominican population is kind of mixed. They primarily went to New York and they have actually been studied by the people studying Hispanic dementia and Alzheimer's disease. And they're finding high rates of dementia and Alzheimer's disease, which correlates with other socioeconomic factors and also correlates with being black. And we know that might be related to outcomes such as dementia. And of course, sometimes they end up generalizing to all Hispanics and that's not the case.

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Dr. Markides
But so anyway, to us, that's a population that is different. And so is the Puerto Rican population.

Dr. LaVeist

So have the findings been similar for other groups, such as Chinese immigrants or immigrants from Europe or Africa? Have we found the same pattern there, where there's this healthy immigrant effect?

Dr. Markides

I think you want some of the healthiest Americans are people born in Africa. You colleagues, people you know, have shown that in their studies, that, of course, they select, many of them are selected as professionals, and they have come a long way. So, people that come a long way tend to be selected more, and then we have that advantage showing up in people coming out of Asia also.

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Dr. Markides
Europeans are not as selected. They are not as selected because it's easier for them to get a visa. And I'm talking about Europeans, Western Europeans. And so that's an interesting finding. And that's really what led me moving to looking at the immigration history of Canada and Australia, the other two that I talk about in my second paper.

Dr. LaVeist

What's really interesting about this though is so immigrants come to the United States and when they come, well the Mexican-American immigrants that you study, they come to the United States and their health status is better than Americans, even though they're coming from a country that overall, where overall the health status is worse than the United States. They're doing better, but then over time their health starts to decline. Talk about that. What happens?

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Dr. Markides
Well, what happens when immigrants come in, let's say middle age or in the younger adulthood, and they live their lives and their jobs, and the primary theory in the literature has been a negative acculturalization, they assume the bad habits of the native society. And people started pointing out to obesity as a central mechanism, whereby immigrants become obese like the native-born, and that leads to heart disease and other things. The other thing that people…

Dr. LaVeist

So wait, so you're saying they begin to live more of an Americanized lifestyle and as a result their health begins to look more like other Americans.

Dr. Markides

Yeah.

Dr. La Veist

Now is that, do they, does that, their health then begin to look more like Hispanic American populations, so say second generation or further, or does it look more like the white population or other or other groups in this country? Who's...

Dr. Markides

The non-Hispanic white population is what the literature has worked for some, but also the Native Mexican Americans who seem at the time to also have an advantage in the middle years.

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Dr. Markides
And that's something people say, well, you know, the immigrants transmitted that advantage to their children. And that's disappearing, really. So, what is happening when immigrants come in, they adopt the lifestyle. Okay, that's the acculturation hypothesis. What some of us have said, me and others, we have applied this cumulative disadvantage theory to their lives in that they have faced challenges, discrimination, and worked at labour jobs and became a true minority population really and when they got older, maybe they lived

longer but they lived longer with more disability, comorbidity, and part of that I should say is diabetes, I need to throw that in because it is a special problem, also in the African-American community. But anyway, they do worse in old age.

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Dr. LaVeist
Now, I know that there was also some back in the 80s and 90s when this work was really just beginning, there was some thought that there might be a bias that some people, they come to this country, they live here, they're in a period of life where they're working. When they're ready to retire, they then go back home. Kind of the salmon bias, I think is what it was called. They return home. What was found about that? Is that what's happening? Is it that people are returning home?

Dr. Markides

Well, you know, it was happening.

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Dr. Markides
The salmon bias is real. It's just not big enough to make, you know, cause the advantage of the Hispanic population and their mortality and health. So that was some of the early findings and later findings saying that people move back when they get older and they die, they want to die in their country of origin. What happens, however, one study showed that some of these people that immigrate back to their country, let's say Mexico, when they get sick, they come back to the United States. And why do they come back? Because they have children here and because they have Medicare. So it's kind of a reverse salmon bias, so to speak. They get sick there, then they come back to the United States because they have the support from the family but also from the government, you know, the insurance.

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Dr. Markides
So Medicare is something that the population of Mexican Americans, 95% have it. So it's actually their advantage there over the middle-aged population which is the less insured, population of the United States Mexican-Americans. So there's kind of an advantage of being old and middle-aged, but at the same time, you do have the issues. Or the convergence to the native levels is a hypothesis people use. Coming in healthier, may you converge. And women seem to be doing that faster than men.

Dr. LaVeist

Interesting. So, I asked you about your more current thinking on the Hispanic paradox. I mean, you've been working on this issue for like 40 years now.

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Dr. LaVeist
And you published an article in 2018 in the Gerontology Society of America, GSA publication. Tell me about that article. What did you find there and how is your thinking about the Hispanic paradox evolved over the last four decades?

Dr. Markides

Well, you know, that was basically the evolution. It's actually ended up being published in the Gerontologist in 2019. And it was the Klemire Award Lecture, so to speak, really, in Gerontological Society. It was quite an honor. But it really kind of evolved my thinking and my colleagues' thinking.

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Dr. Markides
And we started really going beyond the United States to look at other countries that were immigrant destinations. So Canada was one, close by. And the other one was Australia. And what we found in those countries was kind of similar. The immigrants from non-Western origins going to Australia, for example, were advantaged. The immigrants going from the UK were not. And it was a lot easier for them to move to Australia and get a visa and so on than it was for the Chinese and some of the other Asian groups that really went to Australia in big numbers in the 90s and since then. So, there was that. We saw that and we thought, you know, it's happening in other places. And it's happening in Canada also. Canada showed the same things. And then we wanted to see why isn't it happening in Europe? And the problem with Europe is you have a million countries and a million studies, or a million, so to speak. And then the data have been kind of inconsistent there. And some of the advantages was living in immigrant, Hispanic neighborhoods confers an advantage to people.

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Dr. Markides

Okay, if you move to San Antonio, maybe Los Angeles, West Side and so on, you live in an environment that is kind of similar. They speak the same language, they eat the same food, the families and friends are around, the church is Catholic instead of something else. There are some of these sociocultural advantages outweigh the disadvantage of living in communities that lack other resources, so to speak. We saw that in Europe, you know, that's not the case.

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Dr. Markides
At least studies in France and maybe in the Netherlands are showing that if you live in an enclave, in a barrio in the southwest enclave in Europe, let's say, then you are not benefited from integrating into the larger society. So there is a difference with Europe, but Australia and Canada definitely support what we're finding here. That was the impetus to write that paper. And then of course you began looking at why is this still going on? You know, and we

see a lot of changes, a lot of changes in the family. We see people migrating away from the Southwest and what's happening to the people left behind. The advantage continues. And of course it was disrupted by the pandemic, by the way, with the mortality of Hispanics and African Americans took a dive. And you expect that to go back.

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Dr. Markides
So that's the thinking at the time was what other factors are there? We talked initially, we talked about diet, and we talked about genetics. Well, genetics is kind of a residual category. If you cannot explain things through the psychosocial factor, you say, well, it must be genetic. And sure enough, in the 2000s, we see people out of California. Stephen Horvath is a leader of that group at UCLA, basically pointing out there may be some genetic factors that account for the advantages of the Mexican-American population.

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Dr. Markides
And basically, talking about slower aging, so to speak. And, you know, I have some questions about that. And that is based on people who are Mexican-Americans in the Central Valley of California, and they were living in the samples and so on. And so, there's a lot to be learned about that. But it's a promising avenue to follow.

Dr. LaVeist

You think the genetic aspect is promising? I'm actually always skeptical of any genetic explanation for a population phenomena, because there's so much genetic variation within every population. There really aren't genetic characteristics that are unique to any population.

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Dr. Markides
That's why we were kind of opposing the notion that this study, California, was like an in a limited small area, California, is generalizable to Texas, for example, and to other areas. So there's a lot to be done from there.

Dr. LaVeist

I wonder if this pattern also exists in middle-income countries. So like, for example, in Mexico, there's a lot of immigration from Central America. Do you still find that pattern? Or in Africa, there's a lot of immigration into Nigeria from other parts of Africa, or even Brazil, other countries that are more middle income. Do you still, do you know if that pattern has been found there as well?

Dr. Markides

You know, the publications are n**ot o**ut in some ways.

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Dr. Markides
Some of the situations may be different. Some of the immigration, let's say, of Central America to Mexico, they're really on their way to the United States, many of them. And that's why they're being.

Dr. LaVeist

Well, many of them stay. Many stay in Mexico, too. I suppose, too.

Dr. Markides

So, the question is to really study them, to have enough to study them. And my guess is that there are some advantages in the people that are able to survive the migrant trip, so to speak. And so that's a really good point to begin studying migration.

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Dr. Markides
The other thing, though, that is kind of cloud some of these things, it's the migration of refugees. Refugees are different. At least refugees to the United States and to Europe, they seem to be disadvantaged.

Dr. LaVeist

Yeah, I wonder, when you talked about the European findings, I actually thought about that and I wonder if those studies accounted for refugees versus immigrants and migrants. I mean, they really are not the same groups of people. And I think people who are voluntarily migrating, you have a selection there. That seems logical to me, but for refugees who are not voluntarily migrating, I wonder if you see any advantage there.

Dr. Markides

Well, you know, the last paper that you saw, we pointed that out as the refugee experience in Europe, in Germany, and some of the other continental countries, the Netherlands. It's so recent, really, and it relates to Iraq and Syria now primarily. And there's a lot of interest by the Europeans now in studying that.

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Dr. Markides
There are people that might be allowed in, unlike the voluntary immigrants. And they're people who are disadvantaged, and they're people who are in trouble, so to speak. Some of them do better, some of them do worse, but it is something that we need to study more. And of course, there is refugee migration throughout Africa that we're totally ignoring because

we're not studying Africa. The aging in Africa, it's coming out of South Africa primarily now. And increasingly from countries like Nigeria, Uganda, and Tanzania. So, but it's not developed really yet. But it's nice to see aging in Africa developing. And 10 years ago, as you know, I've been an editor of Aging and Health for 35 years, so I've seen the field change. And if we want to talk about that, some of the welcome things I like, aging out of Africa and aging out of other countries. And some of the most exciting and most frequent papers I get are coming out of China. And now slowly out of India because they have the large studies, they have the large universities, and they are smart people. I mean, they get well, they get educated, smartest maybe not the word, but they get educated and they speak amazingly good English at times.

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Dr. Markides
They get screened and they get help. And the papers that we obtain tend to be reasonably good from some of these foreign countries, China being number one right now.

Dr. LaVeist

I'm really glad to hear that. And we here at Tulane, we have anywhere from 18 to 23, 24 percent of our students are from abroad, and many of them go back to their native countries and work in academia. We've got quite a number of alumni who are working at universities in China and in Taiwan and India and other parts of the world. And so maybe and hopefully, I'd like to believe that some of those papers you're getting are our alumnus writing about their country,

Dr. Markides

The people going back, the people that collaborate with the locals.

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Dr. Markides
And the problem with China right now that I face as an editor, okay, is that there's so much coming by so many different people because they have so many different studies that it's hard to distinguish what's new. And when they first started the publishing, let's say 15 plus years ago, the editorial board members said, yeah, you're going to publish this because a quarter of the population lives there. Blah, blah, blah, disability in China, well, you know, disability in China is all over the papers now that we're getting.

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Dr. Markides
And a lot of them are really copying what's been done in the West, and for good reason in many cases, but it is somewhat problematic for an editor to see so much coming from a single place. Interesting, we're getting papers out of Iran, you know, not a friendly country to the United States, but they have a lot of universities, despite their system whatever you wanna call them, a lot of universities are good. And they are producing really ambitious people who are working hard. And then they see the United States, and I suppose maybe the UK, as a place for them to publish their papers. And most of the papers we get from the Journal of Aging and Health now are 72% from foreign countries. So it shows you the change we have seen over the years. When I first started in 1989, hardly any came.

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Dr. Markides
And they came from Denmark and Canada and Australia. Now they're coming from all over the place. It's a nice time in some ways. You know, you see aging all over the world.

Dr. LaVeist

So, you know, this project we have, the Partnership for Advancing Health Equity, we have members that are from many different sectors. I mean, that's the point of the project, that we have people from academia, but we also have people that are working in community-based settings.

0:45:04

Dr. LaVeist
We have people in the private sector, people in government, philanthropy. Now, talk a bit about these other sectors and how does what you've been able to uncover in your research, how does this inform their work? What should they make of this? Say someone in government or someone in the private sector.

Dr. Markides

Yeah, you know, you're talking about equity, of course, which is all of us, it's our goal, it's equity, right? In health and really in other aspects of life, is equity and coming from all sectors of life and academia and other aspects of people who are concerned about the well-being of people and older people.

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Dr. Markides
And one of the things that we want to see happen right away is we want to see everybody have health insurance in this country, being the only one, the only Western country that doesn't have really a national plan. There are attempts to move that way. And my feeling, and I think others feel that way, that solving that, providing health insurance to everybody, it's not the only solution. It's moving in the right direction, but it's not going to solve the

equity problems we have. We have seen a lot of inequality beginning early on in life and increasing in the last few years. And how do you fight that? In aging, for example, some of the hottest papers coming out are people going back to childhood and say, early childhood conditions, it's a huge area in aging. I'm trying to explain the health status of older people by their early life conditions and how the early life conditions influence the midlife conditions and influence the older years.

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Dr. Markides
So early life conditions is something that needs to be addressed. How you address it is not easy. It is, we're pointing out, people are pointing out that it is something that needs to be addressed. And what the field is actually looking at is the socioeconomic status of the parents, or whether they are divorced or not, or whether they have enough money and so on, and whether they were sick as children. And kind of nonpolitical in many ways. And to think about the early life conditions for a lot of people in this country who grow up to face issues and to be subjected to problems later on. A lot of the problems are beginning childhood, I'm sorry, and they begin in our schools and they begin in our communities. So strengthening communities and strengtheni**ng schools is something that, and of course we're seeing a lot of people wanting t**o get out of the profession of being teachers.

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Dr. Markides
And I remember reading somewhere that people in Finland, school teachers in Finland, earn as much money as doctors and lawyers and so on. And they enjoy a high status. And so, we don't have that here. And maybe we should not, I don't know, I'm not going to say. But just to point out that the early life conditions are really the cause of a lot of the problems that we have to face in this country. And of course, it comes to policy and law. Okay. I just saw yesterday that Oxford University Press has promoted the use of thousands, hundreds of papers they publish in their various journals and books and so on, on law and policy and equity. Okay, you may have seen it, it came out yesterday. So there is a lot of interest and a lot of interest in factors. And of course, you know, there are political issues and how to implement policy to address early life conditions is the number one factor I see.

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Dr. LaVeist
Yeah. So you're in, I think, a particularly good position to address this question I have. As a journal editor, what do you find promising? What are the new things that you're seeing, you know, scholars coming up with to address health equity that you think show promise that either need more research or that you think is ready to be applied to policy or programming? Anything that piques your interest?

0:49:54

Dr. Markides
You know, in aging, of course, you know, there's so much attention to aging and well-being of older people and how early life conditions or where they live, communities and their jobs and so on. All of these factors influence it. It's a really good sign. There's a whole lot of interest. Part of my problem in the National Institute on Aging's programs and funding, they have funded so much, spent so much money on Alzheimer's disease, and for so long now, and we're not seeing a lot of progress there. But we're seeing some things that are promising in that there are a lot of people interested in cognitive function.

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Dr. Markides
It used to be that in the 70s and 80s we were interested in life satisfaction as an indicator of successful aging, so to speak. And then in the 90s we went to depressive symptoms and psychological distress. And so nowadays the number one outcome of the quality of life of older people is cognitive function. And, you know, a lot of people have cognitive problems, but, you know, they tend to be concentrating in higher years, of course, and dementia, of course.

Dr. LaVeist

It seems like just an observation of what you just said, going from quality of life to psychological distress to now cognitive function, it seems like we're lowering the bar of what it...

Dr. Markides

Well, we're lowering the bar and paying more attention to medicalized well-being, so to speak.

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Dr. LaVeist
Yeah. So, I mean, you're saying early on in the 80s, you said people were focusing on quality of life. So people being happy is what we were focusing on back then. And now, and that was how we defined successful aging, but today succesful aging is simply the fact that you still have cognitive function, regardless of whether you're happy, regardless of whether you're living in distress, seems like you're lowering the bar.

Dr. Markides

Well, what bothers me about a successful aging literature, and hopefully we're going away, is the emphasis that you have to be successful, you don't have to be disabled. Wow, give me a break, you know, there are a lot of disabled people who are very happy and they contribute.

0:52:29

Dr. Markides
I think of the famous physicist Dawkins, recently in the UK, wow, he was disabled, he had all kinds of problems, but wow, what a tremendous contribution to the world, his work has started, and the meaning to his life and his family members and so on. So, focusing on being disabled does not mean that you're not happy or you're not contributing, you're not, so we're hopefully moving away from that. And we have moved unfortunately to cognitive function and dementia. And part of the reason we have moved there is because of all the money that Congress is giving us, is giving NIA and other agencies to spend on Alzheimer's disease.

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Dr. Markides
There's such a fear of Alzheimer's disease. And not by the people in the legislatures around the country and Congress that tend to be old, or if they're not old, they have parents with problems. So there's been a disproportionate focus on dementia at the expense of others.

Dr. LaVeist

Well, clearly, that's important, research on dementia. But the need for not having dementia, to me, I just don't see how you define that as successful aging, something that does not mention.

Dr. Markides

There's one more thing I'd say about the emphasis on dementia. I don't know if you remember in the 80s, people were saying there was a lot of work on caregiving.

0:54:21

Dr. Markides
And a lot of caregiving at the time was disabled, very old, frail, and so on, some cognitive. A lot of work on caregiving. And people are saying, well, do we need another, Stephen Zarek, my friend, famous psychologist of age, do we need another study of proving that caregiving is stressful? And caregiving, I'm not blaming him, but caregiving kind of came out of fashion, okay? And until there was so much money spent on dementia and cognitive function, that caregiving became important again. And of course, I benefited too, of course, our study of the very old Mexican American. We're still in the business, you know, for 30 plus years with Mexican-American. And there's a lot of work on caregiving. And it's important because caregiving of older people, whether they're demented or disabled, it's important.

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Dr. Markides
It's important because in minority populations, a lot of caregiving is done by women. Some of them have to quit their jobs to care for families. And they do so just because of cultural factors that say, you got to take care of your family, right? And so they may quit their jobs

and they compromise their future. And we don't see the more advantaged non-Hispanic white population, but we do see some of the minority populations.

0:55:56

Dr. Markides
The negative effects appear to be positive in some ways, but also negative effects.

Dr. LaVeist

So, what's next for you? What do you see as your next phase of your career?

Dr. Markides

Well, one of the things I have done in the last five years is to apply for Resource Center for Minority Aging Research, which is Rick Meier, all over the place. And Michigan had one of the first ones, James Jackson, of course. And I don't know if you know, I published a special issue honoring James Jackson.

Dr. LaVeist

Oh, no, I didn't see that.

Dr. Markides

Yeah, I'll send you a copy because it's Robert Taylor.

Dr. LaVeist

Oh, yeah.

0:56:45

Dr. Markides
He had a lot of young scholars who were students and influenced by James and so on to write papers and some of the Rickmore scholars. The research centers for minority Asian research, which we have done well, we have to compete again to extend it. And what we are actually doing there is something useful. We are promoting the careers of young scholars, primarily faculty, who need help to move into minority-aging research and get the mentoring to go ahead and become independent investigators. That's something we are doing and other agencies are doing. I think that we'll deal with the issue of equity, okay, is to bring investigators and people doing the work who are from the minority communities and so on.

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Dr. Markides
So that's a big part of my life and I'm at the stage in my career that I don't care so much about myself, I care what I contribute to other people, especially my younger scholars,

colleagues, students, and so on. So we're looking to extend that and continue to do our work. And there are others doing good work too. I see that as a real plus, not just me, but for others. And of course we're focusing on the Hispanic population. And they're hooking up with a Hispanic serving institution which is UT Texas San Antonio, that is heavily Hispanic, and we're looking out with them and trying to get them to help us, and we'll help them. But you know, that's something we're doing, and others are doing with their own institutions, but we're focusing on the Hispanic part.

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Dr. Markides
We are strong in the Hispanic age, not just my study, but also the Mexican health and aging study, which we are linking with the United States, and migration, and so on. Rebecca Wong, my colleague, is a PI of that. And that's another study that's been going on for a while. We value, and we value what that contributes to aging in the Hispanic population in the United States and the Mexican-American population.

Dr. LaVeist

So you're talking about the new work that you're doing or continuing with the next generation of scholars. Let me preview kind of what you'll be telling them. What advice would you give to a person who's just beginning their career, who is going down the same path that you've been working in?

0:59:34

Dr. LaVeist
What advice would you give them?

Dr. Markides

Wow. Yeah, some of the mistakes I made as a young man. One of the best things I tell people now is to listen to criticism. And young people have a hard time sometimes. And I had too when I was younger. I thought I was on top of the world. Maybe you weren't one of us in those days. You were a good young man. And take criticism from senior people.

1:00:06

Dr. Markides
They're not trying to criticize you, they're trying to help you, by and large. So they're mentoring, accept mentoring, in other words, from scholars. And another thing I've learned over the years, of course, related to that is that some of these younger people that are coming on board are better than we were, and they're giving us advice. And they're better in the technical aspects of research than we were. Maybe not so much conceptually.

1:00:40

Dr. Markides
And I see myself as conceptually helping people think beyond the facts, okay? Then conceptually think beyond and generalize. And that's what we do in science. We create theories, hypotheses, and so on, just so we can summarize the knowledge we have so it has lasting influence on the lives of others. And that's something I tell my students and also young people I work with. Take mentoring seriously and listen to criticisms and work hard.

Dr. LaVeist

That's great advice.

Dr. Markides

It's not an easy life to make it in academia necessarily. No.

1:01:24

Dr. Markides
And that's why we have these programs trying to help people. Yeah. And people from minority communities too. And that's what the RICMAR is doing. Yeah. And of course the other thing is continuing my Hispanic epi study, which we started in 93, 94, it's still funded. We were kind of short-changed during our recent years because we had to stop our interviews because of the pandemic. And as soon as the pandemic is over, we're hopefully going to apply for more money to add a new cohort. What a new cohort is going to do for us is going to tell us where the population is going. Is it getting better in health? Is it getting worse? Some of our data early on for people 75 and over showed that they were getting worse. And they were getting worse in disability, cognitive function, and other well-being measures, primarily because of diabetes, primarily because of the cumulative disadvantage theory I mentioned earlier in older people.

1:02:35

Dr. Markides
And they were getting worse in the 90s and 2000s and mid-2000s. They were getting worse in the general population. The general population was getting better in the very old people, not in the young old people who seem to be getting worse nationally and in other countries because of increases in obesity and diabetes and related factors. But among the very old, we have seen some improvements in the general population cognitive function and dementia. We are looking forward to maybe getting in a cohort and study trends in the health of the population, especially in old age. Hopefully, we'll be successful.

Dr. LaVeist

Dr. Markides I'm sure you will. Thank you for this great conversation. As always, it's been a pleasure talking with you.

1:03:30

Dr. LaVeist
And thanks to our listeners. We hope you found this engaging, Tune in for our next episode.

OUTRO

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