

Message from the Editors

The Road Ahead—Barriers and Paths to Improving AAPI Health

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A major challenge facing those working on Asian American and Pacific Islander health is the decision makers' inattention to the unique problems and needs of this population. Although much of this neglect is rooted in the lack of political power, which is discussed in detail in *AAPI Nexus* 2:2 (Summer/Fall 2004), ignorance also compounds these issues. In addition, what little is known is not widely disseminated. Several factors hamper the development of information about the population's health status: the invisibility of the population, a failure to collect data on the population as a whole as well as its constituent subgroups, the diversity within the category AAPI, and simplistic and often unfounded assumptions about the health of this population. Moreover, the stereotype of AAPIs as being the Model Minority has obscured the myriad health problems and the poor health of many in our communities.

AAPI Nexus issued a call for papers in 2004 to illustrate the multiple levels of forces impacting the health of our communities, and to address the disconnect between the available data and the reality of AAPI health needs. The nature of our highly heterogeneous communities cannot be accurately assessed using the models of health care access and health status developed for the dominant ethnic population. Instead, the analysis requires an ecological perspective that places AAPI issues within the power structure of the larger U.S. society.

Background

AAPI health issues are a result of the social, historical, and racialized context of Asian Americans and Pacific Islanders in the United States. Efforts to address the disproportionate burden of disease and illness require recognition of this past context in light

of the changing demographic composition of the AAPI population in the current political climate.

Table 1 reports the top five major health problems facing AAPIs. Unique to AAPIs is the occurrence of cancer as the number one cause of death (Fried et al. 2003). For all other groups, cardiovascular disease is number one. Notably, the five major causes of death are the same for AAPI men and women, and diabetes is the fourth most frequent cause of disease. For other ethnic groups diabetes is number six. AAPIs have diabetes rates 2-5 times that of non-Hispanic whites.

Table 1. Top Five Diseases Among AAPIs

| All AAPIs, All Ages | Men 45+ Years | Women 25+ Years |
|----------------------------|-----------------------------------------|-----------------------------------------|
| 1. Cancer | 1. Cancer | 1. Breast/cancer |
| 2. Cardiovascular disease | 2. Cardiovascular disease | 2. Cardiovascular disease |
| 3. Cerebrovascular disease | 3. Cerebrovascular disease | 3. Cerebrovascular disease |
| 4. Diabetes Type II | 4. Diabetes Type II | 4. Diabetes Type II |
| 5. Accidents | 5. Accidents/ Chronic lower respiratory | 5. Accidents/ Chronic lower respiratory |

Source: National Vital Statistics Report, 2004

The summary ranking in Table 1, however, fails to capture the complexity and diversity within the AAPI population. Less than 10-15 percent of all diseases are caused genetically. The remaining 85-90 percent of diseases are related to lifestyle choices such as diet, exercise, smoking, birth rates, and age at first birth, changing sexual practices, and environmental risks. Culture can also affect the utilization of healthcare, such as the use of screening and early detection practices. Studies of AAPI groups who have migrated to the U.S. indicate that such lifestyle factors appear to account for a major portion of the variance in disease incidence and mortality rates. Culture, however, is not static, particularly for immigrants because they undergo relatively rapid adoption of U.S. lifestyle patterns and lose some of the protective aspects (as well as risk

factors, such as smoking) of their traditional patterns. As AAPIs Westernize their lifestyles, their disease profiles begin to mirror those of the dominant U.S. society, and the change becomes apparent within one generation (President's Advisory Commission on Asian Americans and Pacific Islanders 2001; Zane, Takeuchi, and Young 1994). Some diseases, such as breast cancer and diabetes, occur at an even higher rate than for non-Hispanic white Americans. The patterns of change, however, vary among AAPI subgroups due to differences in traditional cultural practices, immigration histories, levels of adoption of dominant American lifestyles, and socioeconomic constraints. For example, some groups consume diets very high in sodium such as soy and fish sauces, and pickled, smoked and salted foods, which contain nitrates that increase the risk of stomach cancer (the highest rates in the world are in Asia). Highly peppered foods may also contribute to higher stomach cancer rates, which could indicate why Korean American men have the highest rates of stomach cancer in the U.S. South Asians, who often cook with *ghee*, a type of butter, and fry many foods, have some of the highest rates of diabetes and cardiovascular diseases among AAPIs. Over 90 percent of Asians and Pacific Islanders are lactose intolerant, and calcium intake is lower than U.S. diets. Many elderly Asian American women suffer from osteoporosis, which has a higher mortality rate than all female cancers combined.

Diet is the common denominator for chronic diseases. Traditional AAPI diets are high in complex carbohydrates, fruits, and vegetables, and low in saturated fats and total calories. Such diets are protective against heart disease, diabetes, and the major cancers in the United States. Some aspects of traditional diets may, as indicated above, become problematic, however, when coupled with an increase in overweight, which exacerbates the risk factors for chronic diseases.

The Westernization of Asian American and Pacific Islander diets negatively affects their overall health status. Animal meat and fat generally replace fish as the primary sources of protein. Simple carbohydrates, such as breads, sugared confectioneries, and fast foods, take the place of more complex carbohydrates, and the intake of fresh fruits and vegetables drops dramatically. In fact, Asian American youth have the fastest rise in obesity rates in California of all ethnic groups. From 1994-2003, overweight has increased more sharply for California AAPI low-income children (from 7

percent to 15 percent) than for any other ethnic group. Increasing weight gain portends poorly for the development of the major chronic illnesses. Self-reported height and weight data from the 2001 California Health Interview Survey show that 42 percent of AAPI men and 22 percent of AAPI women were overweight or obese compared to 63 percent for men and 45 percent for women in the overall population. Fifty-five percent of AAPI men and 42 percent of AAPI women reported significant weight gain (> 20 pounds) since the age of eighteen years, only slightly lower than the proportion in the overall population experiencing major weight gain in adulthood (Mirzadehgan, Harrison, and DiSogra 2004).

The rates of cardiovascular disease, diabetes (rates of 15-20 percent compared to 4 percent for the U.S. population), and cancers associated with obesity and reduced roughage (30 percent of all cancers), such as breast, colorectal, and prostate, are increasing dramatically. Certain cancers, however, are reduced compared to their rates in Asia, but still remain higher than whites, such as liver cancer in Vietnamese men with 11.3 times the rate of non-Hispanic whites and cervical cancer for Vietnamese women with 5 times the rate of non-Hispanic white women. The incidence of tuberculosis is almost 15 times that of whites for Chinese and Filipinos, and Hepatitis B carrier rates are about 14 percent for AAPIs compared with <0.2 percent for all ethnicities in the U.S. (Kagawa-Singer 2003).

The above illustrates how differences in culture and Westernization of lifestyles have profound implications and produce enormous variations in outcomes across AAPI groups, and is indicative of a more complex set of phenomena and dynamics than just genetic variations. No single article or even a limited collection of articles can adequately document the AAPI experience in relation to health status. Nonetheless, this issue and its companion issue in 2006 make an important contribution in that direction.

Diversity of Coverage and Common Threads

The six articles in these two issues focusing on health cover the three categories adopted by *AAPI Nexus* to create forums for voices from multiple areas of expertise, and to disseminate data, information, and knowledge to our diverse audience. "Practitioner's Essays" are opinion-based articles that give the writers an opportunity to broadly discuss the challenges and accomplishments facing AAPIs,

and to lay out an agenda for action. Takeuchi and Hong; and Liou and Hirota contribute the two Practitioner's Essays for this and the other upcoming issue. In honoring the journal's overall mission to bridge the world of research and practice, we seek applied social-science and policy-oriented research articles, such as those by Ponce and Gatchell; and by H. Chen et al. Finally, we include two articles (C. Chen et al.; and Tao et al.) in the "Almanac Section," which presents new data or data not readily accessible to our audience and methodologies relevant to studying our community. Although the three categories can and do overlap, each of them has a distinct orientation, which collectively pursues *AAPI Nexus's* mission.

These articles cover some common themes across a wide range of AAPI health issues. Authors from the academic, governmental, and professional worlds address the multiple levels of factors that impact AAPI health. These authors bring together their decades of experience in conducting research, running and evaluating health programs, and advocating on behalf of AAPIs. Geographically, two articles present a state-level view (Tao et al. with a view from Illinois, and Ponce and Gatchell with a view from California), and three articles are anchored in Chinese American communities in Oakland, Boston, and New York (Liou and Hirota; C. Chen et al.; and H. Chen et al.). The focus on one ethnic community is not intentional. Although we sought articles covering various groups, the final selection was ultimately the product of the submissions we received and the review process. While this explains the outcome of including these three articles, it also points to a possible inherent unevenness among AAPI communities. We suspect that because Chinese American communities tend to be more established, larger, and more spatially concentrated, and because more health researchers are Chinese American, these communities tend to be more extensively studied relative to other AAPI communities.

Collectively, the articles also cover a range of topics and issues. Three articles examine specific health issues. Liou and Hirota examine the interaction between a community-based agency and the city to reduce the number of pedestrian/auto accidents, and the C. Chen et al. investigate the prevalence of asthma among inner-city Asian American children who utilize a particular hospital. H. Chen et al. discuss a model program of addressing mental health needs of AAPIs in the primary healthcare setting. Four ar-

ticles cover issues related to the collection and reporting of health data. Takeuchi and Hong emphasize the need for a policy focus to develop a broad framework to guide the type of data that should be collected, including information on historical and contextual factors affecting health status. Data provide the basis for policy decisions, but collecting survey data from AAPIs is difficult and expensive because the population is geographically dispersed and culturally diverse. Thus, alternative strategies are often needed. Ponce and Gatchell describe one method of increasing the sample size of Asian Americans used by the California Health Interview Survey (CHIS). CHIS is the first population-based health survey to oversample Asian Americans and conduct the survey in five Asian American languages. Tao et al. highlight the limitation of data collected by governmental agencies at the state-level, using Illinois as their case study, and utilize the available statistics to document the health disparities suffered by Asian Americans and Pacific Islanders in that state.

Because this is the first foray of Asian American Studies into a focused health issue, we have found it necessary to publish these health-focused articles in two separate volumes. This first issue contains the three community-level articles (Liou and Hirota; C. Chen et al.; and H. Chen et al.), and an early 2006 issue will contain the articles focusing on research and data (Ponce and Gatchell; Takeuchi and Hong; and Tao et al.), including an additional article discussing the limitations of AAPI statistics at the national level.

As researchers, practitioners, and community advocates, the contributors share a common understanding of the dire need for more and better data, information and knowledge. Many of the articles point to the paucity of data and data that suffer from aggregation. Lumping AAPIs together without detailed breakdowns not only belies the diversity of the population but also prevents severely disadvantaged AAPI groups from getting the attention and resources needed to address their health problems. Simple averages obscure the bimodal character of the population and often further marginalize those at the bottom. Notably, for example, the federal government excludes AAPIs as an underserved minority because the available data shows that we are healthy, wealthy and wise. Those left out include at-risk youth, the non-English speaking, and the poor. The problem is worse at the state and local levels. With the possible exception of Hawaii, New York, and Cali-

ifornia, most, if not all, of the other states collect data only in one aggregated category called “Asian and Pacific Islanders,” and worse yet, many do not even collect data in an AAPI category at all. AAPIs remain the anonymous and unusable “Other” (Ghosh 2003). Yet, those of us in the community know the dangerous fallacy of this Model Minority myth and the existence of the undue burden of disease borne by too many of our members. Even when health data are disaggregated, the information frequently does not fully capture the conditions of the poor and limited English segments of our population. For example, simple births to population ratios based on vital statistics collected in this country produce falsely low death rates because it fails to take into consideration misclassification and the “salmon” effect of AAPIs, who return to their home countries to die (Fred Li, personal communication 2003). In today’s world, where the AAPI population is approaching 5 percent of the total U.S. population, the disconnect between the data and the reality is disconcerting.

The articles in this issue also share an implicit consensus that fundamental change and collective action are needed to stem the tide of the rising rates of avoidable disease in the AAPI population. The recommendations range from revising the conceptual framework for data collection and analysis, expanding or establishing health services that are culturally appropriate, linking efforts to improve health to a broader audience, and increasing efforts to improve community awareness and capacity for action. Changes require the injection of AAPI concerns at the policy and programmatic levels and the modification of the practices and behaviors of the AAPI community as well as health professionals. The articles in this and its forthcoming companion issue provide a means for a group of researchers, clinicians, and community practitioners to use their collective written words to address more accurately the growing health needs of our communities. These publications show us the road ahead—both with its obstacles and the lessons learned.

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