

Asian Americans and Pacific Islanders: Health Disparities

Note: The information on groups presented under Asian Americans and Pacific Islanders does not focus on Koreans and Japanese living in the US, since these subgroups are relatively small.

The available demographic and health data on Asian Americans and Pacific Islanders (AAPIs) are usually of limited value because of the attempt to encompass the broad AAPI group, in spite of the enormous diversity among the peoples included. Without disaggregating the data, it is impossible to detect the great variations in income, education, and health status among AAPI populations, hiding serious socioeconomic and health problems both within and between subgroups.

Health indicators for AAPIs overall suggest that this population is one of the healthiest in the US. However, there is great diversity within this group, and marked health disparities exist for specific segments. Women of Vietnamese origin, for example, suffer from cervical cancer at nearly five times the rate for white women. New cases of hepatitis and tuberculosis are also higher in AAPIs living in the US than in whites. (US DHHS, 2000).

Underlying Causes of Health Disparities: Income and Education

Inequalities in income and education underlie many health disparities in the US. Income and education are intrinsically related and often serve as proxy measures for each other. In general, population groups that suffer the worst health status are also those that have the highest poverty rates and the least education. Disparities in income and education levels are associated with differences in the occurrence of death and illness, including heart disease, diabetes, obesity, elevated blood lead level, and low birth weight. Higher incomes permit increased access to medical care, enable people to afford better housing and live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors. (US DHHS, 2000).

Health disparities are believed to be the result of the complex interaction among genetic variations, environmental factors, and specific health behaviors. This section of the Provider's Guide presents information on the traditional health practices and beliefs as well as the health status of different AAPI subgroups:

- **General Information on Asian Americans and Pacific Islanders**

General Information on Asian Americans and Pacific Islanders

Although AAPIs are sometimes seen as constituting a homogeneous ethnic category, the failure to make distinctions among specific ethnic groups can lead to faulty conclusions about important health needs among AAPI clients. Without disaggregating demographic and health data, it is impossible to detect the great variations in income, education, and health status among AAPI populations, hiding serious socioeconomic and health problems both within and between certain ethnic groups. The need to examine the health care issues of *specific* AAPI subgroups (e.g., Chinese, Filipino, native Hawaiian, Vietnamese) is clear. (Zane et al., 1994).

- **History**
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- **Risk Factors and Challenges**
 - Access to Health Care
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 - Parasitic Infestations
 - Smoking
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 - Lack of Knowledge of Risk Factors
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Risk Factors and Challenges

Access to Health Care

- **Providers can help dispel fears and concerns.** Fear of deportation and concerns about jeopardizing their chances of obtaining citizenship or permanent residency can discourage AAPIs from seeking health care. Many recent immigrants and refugees are confused about their eligibility for services and reluctant to visit Western physicians. (Kaiser Permanente, 1999).
- **Lack of familiarity with Western health care systems.** Immigrants who are unfamiliar with Western health care systems tend to underutilize health care services, delay seeking health care, and not adhere to treatment recommendations. (Chin and Bigby, 2003).

Suggestion

Programs can be established to educate AAPIs, especially those new to the country, about the concept of HMOs and how best to use the system. It is important that materials be available in languages that the patients can read.

Lack of Insurance

- **About 19% are uninsured.** In one older study, 27% of Asians were uninsured, compared with 12% of whites, 19% of blacks, and 27% of Hispanics. (Gold and Socolar, 1987). The percentage of AAPIs who were uninsured had declined to 19% in 1999–2001 (three-year average), however. (US Census Bureau, 2002).
- **Limited or no coverage is available for alternative medicine.** Even with health insurance, culturally accepted medical treatments such as acupuncture and herbal medicines often are not covered, which may limit access to health care by Asian Americans. (AAHF, 1990).

Language

- **Language is a barrier.** Access to care via complicated telephone systems that are unresponsive to non-English-speaking clients can be problematic for Asian-American immigrants and refugees. Longer waits for services occur when interpreters cannot be found, and child family members are sometimes called on to interpret. (Chin and Bigby, 2003).
- **Some subgroups, especially the elderly, are not fluent in English.** The percentage of persons 5 years or older who do not speak English varies by Asian-American group: 61% of Vietnamese, 51% of Chinese, 24% of Filipinos, and 24% of Asian Indians are not fluent in English. A very large proportion of Asian Americans over 65 years of age cannot speak English well. (Tucker and Tervalon, 2003).

Suggestion

Ensure comprehension of medical information by asking questions or using an interpreter. (Kaiser Permanente, 1999). Seek patient education materials in the patient's language.

- **Lack of interpreters is a problem.** The absence or limited supply of interpreters and bilingual providers impedes access and communication. Even when interpreters are available, the multiple languages and dialects among different Asian ethnic groups make communication difficult. (Chin and Bigby, 2003).

Parasitic Infestations

- **Incidence of parasitic infestation.** The incidence of intestinal parasitic infestation among AAPIs entering the US has been shown to be as high as 80%, and multiple parasitic infestations have been found in as many as 55% of the Southeast Asian refugees screened. (Hann, 1994).
- **Common types of parasites.** Hookworm is by far the most common (38%), followed by *Giardia* (9%), *Ascaris* (7%), and *Strongyloides* (6%). (Hann, 1994).
- **Southeast Asians at risk.** The prevalence of parasitic infestation varies significantly among different ethnic groups. Hmong are the most frequently infected (75%), followed by Cambodians (74%) and Vietnamese (47%). The distribution of parasite types also varies among ethnicities: *Ascaris* and *Trichuris* are more common in Vietnamese; *Clonorchis* species are more prevalent in Laotians; and Cambodians show more multiple infestations by *Strongyloides*, hookworm, and *Giardia*. (Hann, 1994).
- **School-aged children most heavily infested.** Youngsters less than 4 years old are least infested, and school-aged children are most heavily infested, by *Trichuris*, *Giardia*, and *Strongyloides*. Adults have a majority of the hookworm and *Clonorchis* infestations. (Hann, 1994).
- **Malaria among Southeast Asian refugees.** Although malaria is not a significant problem in the US, it may occur among refugees and travelers from endemic regions or military personnel stationed there. Thus, more than 99% of cases are imported; 55% occur in Southeast Asian refugees, more occur in males than in females, and the highest incidence is in the 10 to 29 age group. Vivax malaria is the predominant form (82%) among refugees in the US. (Hann, 1994).

Smoking

- **Male smoking rate is higher.** Among AAPIs age 18 and older, 24% of men and 7% of women smoke. (Tucker and Tervalon, 2003). Some social structures may encourage negative health behaviors. For example, smoking rates exceed 50% among immigrant male restaurant workers.
- **Females have higher exposure to secondhand smoke.** Female AAPI nonsmokers are exposed to more secondhand cigarette smoke than are male AAPI nonsmokers. It is believed that the women's exposure to secondhand smoke is due to male smokers in the household. (APIAHF, 2001).

Diet and Exercise

- **Diet in the US.** The adoption of Western dietary habits has been shown to negatively affect the overall health status of AAPIs. For example, animal meat and fat generally replace fish as the primary sources of protein. (Kaiser Permanente, 1999).

Suggestions

Encourage AAPIs to retain the positive elements of their traditional diets, but warn them about the risk associated with nitrates in traditional pickled, smoked, and salted foods. Urge more consumption of fruits and vegetables. (Kaiser Permanente, 1999).

When dealing with the Southeast Asian population, pay special attention to nutritional status. Become familiar with the various foods consumed by AAPIs and the nutritional content of these foods. Consult published guides that offer this specific information. (Kaiser Permanente, 1999)

- **Lactose intolerance.** Because 90% of Asian Americans are lactose intolerant, the absence of dairy products is believed to result in a low intake of calcium among AAPIs. (Kaiser Permanente, 1999). Asian women are at high risk of osteoporosis.
- **Traditional exercise is in decline.** A daily regimen of healthy behaviors and exercise is common in Asian cultures, consistent with a holistic view of the mind, body, and spirit as important to wellness. Tai chi, a form of exercise, and qigong, the development of internal energy, are viewed as supportive of longevity, health, and strength. (Chin and Bigby, 2003). Among Asian-American immigrants, however, traditional forms of exercise have declined because of economic demands and work schedules.

Suggestion

Encourage exercise, including traditional exercise, if appropriate. Traditional exercise can be done almost anywhere, alone or with others, and there is no need to purchase equipment or invest in a health club membership.

Stress

- **Adaptation to a new culture causes stress.** Asian immigrants and refugees may suffer from stress-related illnesses (cardiovascular disease, carcinoma, depression, and drug or alcohol abuse) triggered by the stress of adapting to a new culture or by feelings of isolation from the larger society. (Tyler et al., 1991).

Suggestion

Health care professionals need to consider contextual factors, such as ethnicity, personal history, personal characteristics, and sociocultural environment, when providing services to their Asian-American clients. Knowing clients' personal and family histories is crucial to understanding and meeting their health care needs.

- **Education may not reap commensurate rewards.** For some Asian Americans, stress may result from frustration at not reaping benefits in the form of high-paying, high-status jobs

commensurate with their expectations based on their educational level and the status of similarly educated white Americans. (Takeuchi et al., 1992).

Suggestion

Become acquainted with the education or training of your Asian-American patients when taking a social history. (Chin and Bigby, 2003).

- **Separation from family** can be a source of stress for Asian immigrants. Many Asian immigrant families are split households; one member immigrates to the US and is joined later by others. (Orlandi, 1995).
- **Elderly refugees may feel isolated** from the larger US society, whose cultural norms are very different from their own. (Yee, 1990, 1992; Yee and Hennessey, 1982). Family estrangement and generational conflicts can create emotional distress for elderly refugees; these are their most frequently cited problems. (Yee, 1992).
- **Racism** adversely affects the psychoeconomic status of Asian Americans, as is the case for other peoples of color. As a result of a multitude of social forces over which they have no control, Asian Americans may feel alienated and experience identity conflict. These feelings may be accompanied by loneliness, a sense of not belonging, helplessness, powerlessness, low self-esteem, and, for some, loss of a sense of the meaning of life.
- **Denial of stress-related problems.** A culturally negative view of mental illness, drug abuse, and other less apparent stress-related conditions makes early identification, diagnosis, and treatment difficult. These factors, combined with fear of shame and stigma, reinforce the denial of problems. (Orlandi, 1995). Sometimes, a patient's denial of illness is associated with economic factors, such as the need to keep working, or with social factors, such as the inability to ask for help. (Chin and Bigby, 2003).
- **Posttraumatic stress.** Many Southeast Asians have lived through war, dangerous escapes, and refugee camps. Some may suffer from posttraumatic stress disorder.
- **Pressure on children to succeed.** Some Asian Americans emphasize high educational achievement. However, the pressure that Asian-American parents place on their children can be stressful for the children. (US DHHS, 2001).

Pertinent Fact

Research on Asian immigrants has documented how they cope with many stressors, including those created by the acculturation process, stressful life events, employment, and economic hardships. (Kuo and Tsai, 1986; Lin et al., 1984).

Lack of Knowledge of Risk Factors

- **Blood pressure and heart disease.** The lack of knowledge about risk factors or preventive behaviors for various diseases can be a problem for Asian Americans. One study among Southeast Asian populations in central Ohio revealed that 94% of those surveyed did not

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know what blood pressure is, and 85% did not know what could be done to prevent heart disease. (Tamir and Cachola, 1994).

- **Cancer.** Lack of knowledge about cancer risk factors may result in failure to conduct breast self-examinations or to get screening tests, such as mammograms or Pap smears. (Chen and Hawks, 1995). The mistaken belief that cancer is inevitably fatal may also be a factor in lack of screening. (Pham and McPhee, 1992). Although 97% of the women surveyed had heard of cancer, many did not know the common signs, symptoms, and risk factors for breast or cervical cancer.

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