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Resource Paper

Assessment of the State of Ethnic-Specific Health Survey Data

Nadereh Pourat, Ninez A. Ponce, and Roberta Wyn

Abstract

Progress in Asian American and Pacific Islander (AAPI) health data had begun by the 1990s, although the gains have been temporal and localized. This resource paper reviews the Hawai'i Health Interview Survey, the California Health Interview Survey, and the National Health Interview Survey (NHIS)¹ with specific data on AAPIs. We then provide an analysis of the NHIS to illustrate its usefulness and limitations in estimating access to health services of three socioeconomically similar AAPI subgroups—Chinese, Filipinos, and Koreans. The results underscore the need to disaggregate AAPI data. In tandem with recent improvements in the NHIS, other states with a large AAPI population should invest in ethnic-specific oversampling and in-language survey effort similar to what has been done in California.

Introduction

Ethnic-specific survey data are critical to understanding healthcare access and utilization for the diverse Asian American and Pacific Islander (AAPI) populations. Yet relative to its population size, little has been known about what predicts healthcare access and utilization for over sixty nationalities that are grouped under the AAPI racial category. In a review article by Andersen and his colleagues, a tabulation of studies from 1980 to 1994 concluded, "Given the rapid growth of the APIA [Asian and Pacific Islander American] population, this group is underrepresented in the published work. Studies are needed that determine cultural influences on health status and outcomes of the health care system for ethnic subgroups of the APIA population" (Andersen, et al., 1995). Moreover, they concluded that paucity of data, given the population size, was most serious among Filipinos and Koreans.

One contributing factor to the lack of detailed healthcare ac-

cess information on AAPI subgroups has been the relative absence of reliable ethnic-specific survey data for Asian populations in the United States or states with large AAPI populations. These populations are often not sampled, sampled but systematically excluded because of language barriers, or if included, often grouped together due to small sample sizes. In the past, this resulted in frustration among researchers and advocates since the few included groups were often more advantaged segments and did not accurately depict the health of all AAPI groups and furthermore, even among the groups represented, AAPI data could not be disaggregated. Consequently, the state of AAPI health data was either no data, or aggregated data that possibly led to erroneous conclusions about barriers to healthcare for specific AAPI ethnic groups.

Progress in AAPI health data had begun by the 1990s, although the gains have been temporal and localized. This paper reviews three noteworthy survey efforts that have benefited AAPI health data: the Hawai`i Health Interview Survey, the California Health Interview Survey, and selected years of the National Health Interview Survey. We then provide a case study of an analysis of the national population-based survey to illustrate how the information can be used to estimate differences in access to and utilization of health services among three of the largest immigrant Asian subgroups: Chinese Americans, Filipino Americans, and Korean Americans (henceforth referred to as Chinese, Filipino, and Korean for ease of reporting). We conclude this resource paper with recommendations on what needs to be done to improve ethnic-specific health data for the AAPI population in the United States. We focus our discussions on *publicly available* datasets that serve to improve the health of communities across the United States.

Three Examples of Ethnic-Specific Health Data

The National Health Interview Survey, the nation's principal source of data on the health of Americans, is administered as an in-person interview of household members. Conducted annually, the NHIS collects information on a broad range of health issues and provides information on both acute and chronic conditions for a national sample of 40,000 households and over 100,000 persons. During a limited period over the past decade, the NHIS offered information on expanded categories of Asian, and also Pacific Islander subgroups (Mays, Cochran, and Ponce, 2004). From 1992

through 1995, for example, the NHIS released in their public-use file self-reported ethnic identification codes for Chinese, Filipino, Korean, Japanese, Vietnamese, Asian Indian, Hawaiian, Samoan, Guamanian, and other Pacific Islanders. However, with a total survey sample size reduction in 1996, from 1996 onwards NHIS data reverted to the previous policy of identifying only a limited number of AAPI subgroups (Chinese, Filipino, Japanese, Other Asian, and Pacific Islanders) due to confidentiality reasons. A major limitation of the NHIS is that the survey is conducted only in English and Spanish and therefore leaves out any AAPI group that does not speak either language and had no one present to act as an interpreter.

Studies that have used these special data years of the NHIS have confirmed that AAPI subgroups differ significantly in their characteristics and some indicators of access. More Vietnamese and Koreans report poor health than Chinese, Filipinos or Japanese (Kuo and Porter, 1998). In a study comparing seven Asian subgroups, after age-adjustment, Filipinos, Vietnamese, and Asian Indians reported to have higher rates of physical activity limitations than Chinese, Japanese, and Koreans (Frisbie, Cho, and Hummer, 2001). In the same study, Chinese and Koreans had the smallest proportions with a usual source of care, compared to Filipinos, Japanese, and Vietnamese who reported much higher proportions; Koreans had the highest proportions that did not see a physician over the past year, and Vietnamese had the highest proportions with three or more physician visits. Rates of breast cancer were higher for Japanese than Koreans, while 21 percent of Japanese and more than 50 percent of Koreans never had a mammogram screening (Kagawa-Singer and Pourat, 2000). In another study comparing four Asian groups (Chinese, Japanese, Korean, and Vietnamese), Korean and Vietnamese women had the lowest usage of prenatal care (Yu et al., 2001).

In 2001, the California Health Interview Survey (CHIS) was launched, generating a robust data source for several AAPI groups—Chinese, Filipinos, Japanese, South Asians, Vietnamese and Koreans. CHIS is a biennial telephone survey specifically developed to address program and policy needs for California counties and county-groups, and the state's diverse racial/ethnic population (Ponce and Gatchell, 2006). With adult samples totaling over 40,000 each survey year, CHIS is the largest state health survey and

one of the largest health surveys in the United States. As a telephone survey, CHIS systematically excludes households without telephones, thus the poor, the homeless, migrants, and some rural households may be underrepresented. In addition, although the CHIS data provides a rich source of Asian subgroup information, a study evaluating CHIS found that CHIS data might not be generalizable to Asian populations outside of California, given that the demographic profile of California's Asian population differs from Asians who live outside the state (Ong and Ong, 2002). However, unlike most national surveys, CHIS oversamples Asian subgroups (Koreans and Vietnamese), and administers the survey in several Asian languages: Cantonese, Mandarin, Korean, and Vietnamese (Ponce et al., 2004). The example of CHIS as a landmark data source for AAPIs promotes the progress of efforts to improve health data collection for AAPIs nationwide. Not surprisingly, researchers concerned with the AAPI community have responded to good data: since the 2002 release of the first round of the CHIS public-use dataset, numerous studies distinguishing Asian American subgroups or focusing on specific ethnic groups have been published, for example, studies on cancer screening (Kandula et al., 2006; Ponce et al., 2006; Wong et al., 2005); cardiovascular risk factors (Ivey et al., 2006); smoking (Tang, Shimizu, and Chen, 2005; Maxwell, Bernaards, and McCarthy, 2005); overweight and obesity risk (Cho and Juon, 2006); nutrition (Harrison et al., 2005); and physical activity (Kandula and Lauderdale, 2005).

The Hawai'i Health Survey (HHS) is notable because it provides ethnic-specific data on Native Hawaiians, major Asian groups, and the state's considerable multiracial population. The HHS is an annual statewide household survey of health and socio-demographic conditions. Initiated in 1968, it was modeled after the National Health Interview Survey. In 1996 the HHS switched from in-person household interviews to telephone interviews, presumably to contain costs. In 2004, 6,769 households (6,769 adult respondents that were eighteen years of age or older) with 19,699 household members were surveyed.

The HHS provides state and sub-area estimates of gender, age, income, race, education, household size, insurance status, health status, morbidity, and food security to inform planning and evaluation of health services, programs, and problems. The survey chiefly provides surveillance of health and demographic

trends during the intercensal decade, but has been used to investigate the use of complementary and alternative therapies (Harrigan et al., 2006); tobacco use, prevention, and control (Ichiho, 2004); and specific studies focused on Native Hawaiian health (Johnson et al., 2004).

While ethnic-specific AAPI data are at best geographically and temporally uneven, and fail to include the smaller AAPI populations, the available data do show the potential of how the information can be mined and analyzed to provide important insights. Although AAPI subgroup data provides ideally more precise detection of an ethnic community's healthcare needs, cost considerations prohibit representation of smaller groups in population-based surveys. Indeed, additional research could be and should be conducted, and we provide an example of access to healthcare to illustrate both the benefits and limitation of such analyses.

Illustration of Further Analysis of Existing Data

Access to healthcare of ethnically diverse populations is of great interest to researchers and policymakers, since most recognize the existence of health disparities and various barriers to care for these groups. While utilization of services and quality of care can be measured by various sources of data, including insurance claims data and clinic facility data, only population-based surveys can depict a picture of who does and who does not get access to care. Unfortunately, as we discussed, AAPIs are not well represented in most national and state population-based health surveys.

Differences in demographic and socioeconomic characteristics of each subgroup may contribute to differential rates of access to health services. Poverty rates are higher for some groups than others: among AAPI elderly, more Vietnamese and Asian Indians were found to live in poverty than other groups (Tanjasi, Wallace, and Shibata, 1995). Koreans are less likely to have health insurance, and Koreans and South Asians are less likely to have employment-based health insurance and Medicaid coverage (Brown et al., 2000). Immigration and citizenship status varies considerably: more Japanese are native born compared to others; there are higher rates of recent immigration among Southeast Asians (Tanjasi, Wallace, and Shibata, 1995). But the differences in healthcare access among AAPIs may be explained beyond the disparate socioeconomic status and immigration patterns that span the experience of Japanese,

Chinese, Filipinos, Korean, Asian Indian, Vietnamese, and other Asian. Thus, as argued by Takeuchi and Hong, historical and cultural context are often overlooked in AAPI health research, and traditional factors such as socioeconomic indicators may imperfectly explain the health behaviors of AAPI groups (Takeuchi and Hong, 2006).

In our example analysis, we take a different approach in exploring the distinct cultural needs of specific AAPI subgroups in lieu of explicit measures of historical and cultural context of institutions and communities (which would entail further data collection and acquisition of datasets with contextual variables). Our approach is to purposely focus our analysis on three groups—Koreans, Chinese and Filipinos—that have comparable mean sociodemographic characteristics.

We used data from the 1995 and 1996 National Health Interview Survey (NHIS) to examine variations in healthcare access and utilization among Koreans, Filipinos, and Chinese, with whites serving as a benchmark. We obtained information on demographic characteristics and healthcare access from the core survey for individuals eighteen to sixty-four years of age. Information on health insurance coverage came from the health insurance supplement. In 1996, the Health Insurance and Access Supplements were administered in the second half of the year only, and therefore, had half the sample size of the larger core survey. Population weights were adjusted to account for combining the data for 1995 and 1996 and to represent the population of AAPIs in the U.S. for the 1995 to 1996 period.

We organized the indicators of access to care based on the Andersen model of healthcare access and utilization (Andersen, 1995). Based on this model, access to care is predicted by *predisposing*, *enabling* and *need* characteristics and is measured by whether the person had a doctor visit in the past two years compared to those who had not seen the doctor for more than two years ago. A visit to the doctor longer than two years ago may represent underuse of acute care services as well as specific preventive services such as blood pressure checks and cervical cancer screenings.

Based on the conceptual model, we selected age, education, gender, immigrant status, marital status, and working status as indicators of *predisposing* characteristics of the population. Health insurance coverage, having a usual source of care, and federal

poverty level were selected to represent the population's *enabling* characteristics. To indicate the level of *need* for healthcare, we selected self-reported health status and having had a bed-day in the last year.

We investigated whether Koreans, Filipinos, and Chinese differed in access from AAPIs as an aggregated group or from whites through descriptive analysis and unadjusted logistic regressions. Next, using multiple logistic regression analyses to adjust for all other characteristics we specified in our conceptual model, we identified similarities and differences in predictors of access of AAPI subgroups with that of AAPIs as a group. We also identified similarities and differences in indicators of access between AAPI subgroups and whites to highlight disparities that potentially are not experienced by whites. Standard errors of all estimates were globally adjusted by a conservative factor of 1.2 to account for the stratified clustered sample design of NHIS.

Results

The demographic, socioeconomic, and health status characteristics of the sample are presented in Table 1. The data confirmed that as a group, gender, marital status, and health status of AAPIs were similar to that of whites, although AAPIs differed from whites in age, insurance status, income level, reported bed-days, immigrant status, and educational level. Koreans, Filipinos and Chinese had very similar education levels, and shared other demographic and socioeconomic characteristics that constituted non-extreme values that have led to the previous depictions of the bimodal nature of AAPI group (Lin-Fu, 1988). However, health insurance and health status differences emerged in various comparisons. Filipinos had the lowest rate of uninsured, Koreans had the highest proportions of self-reported fair or poor health, and Filipinos had one of the highest proportions reporting one or more bed-days in the last year.

AAPIs, as a group, were significantly less likely than whites to have seen a doctor in the past two years (Table 1). Chinese and Koreans have seen a doctor in the past two years less frequently than whites, but Filipinos had a rate statistically similar to whites. The predictors of a doctor visit in the past two years for Chinese were poor health (increased likelihood) and one or more bed-days in the past year (increased likelihood); similar to AAPIs and whites

Table 1. Sociodemographic Characteristics of White and AAPI adults, Ages 18 to 64, 1995-1996

	White	Total/AAPI ¹	Chinese	Filipino	Korean
Sample size	64,240	1,565	714	619	232
Utilization of care					
Had a doctor visit in the past year	87% (0.18%)	79% (1%)	76% (2.1%)	85% (1.9%)	70% (4.2%)
Demographics					
45 to 64 Years of Age	35% (0.2%)	27% (1.0%)	27% (2.2%)	32% (2.4%)	24% (3.8%)
Female	51% (0.2%)	52% (1.1%)	52% (2.4%)	55% (2.5%)	53% (4.4%)
Not married	31% (0.2%)	34% (1.1%)	32% (2.3%)	33% (2.4%)	28% (4.0%)
Education					
Less than High School (0 to 11 years)	11% (0.1%)	11% (0.7%)	11% (1.5%)	10% (1.5%)	8% (2.4%)
High School Diploma (12 years)	38% (0.2%)	24% (1.0%)	20% (2.0%)	20% (2.0%)	22% (3.7%)
College (13 or more years)	51% (0.2%)	64% (1.1%)	69% (2.3%)	70% (2.4%)	70% (4.1%)
Not Born in U.S.	5% (0.1%)	82% (1.0%)	83% (1.9%)	80% (2.0%)	91% (2.7%)

Socioeconomic							
Income less than 200% of Poverty Level	18%	24%	25%	18%	34%		
	(0.2%)	(1.0%)	(2.1%)	(2.0%)	(4.3%)		
Lives in Non-Working Family	22%	30%	31%	20%	32%		
	(1.0%)	(1.1%)	(2.2%)	(2.1%)	(4.2%)		
Uninsured	15%	21%	24%	11%	38%		
	(0.2%)	(1.0%)	(2.1%)	(1.6%)	(4.4%)		
Health							
Fair or Poor Health	8%	8%	7%	7%	11%		
	(0.1%)	(0.6%)	(1.2%)	(1.3%)	(2.8%)		
Had One or More Days in Bed Last Year	47%	37%	30%	37%	36%		
	(0.3%)	(1.1%)	(2.2%)	(2.5%)	(4.3%)		
Access							
Two years or Less Since Last Doctor Visit	87%	79%	76%	85%	70%		
	(0.18%)	(1%)	(2.1%)	(1.9%)	(4.2%)		
Have No Usual Source of Care	15%	20%	24%	10%	32%		
	(0.18%)	(0.9%)	(2%)	(1.5%)	(4.2%)		

Note: standard errors of estimates are presented in parenthesis.

¹Total AAPI population includes other AAPI subgroups including Japanese, Vietnamese, Asian Indians, and Pacific Islanders.
 Source: Author's analysis of 1996 and 1996 National Health Interview Surveys.

Table 2. Predictors of Having a Doctor Visit in the Past Two Years, Ages 18-64, 1995-1996

	White	Total AAPI ¹	Chinese	Filipino	Korean
Effective Sample Size	59,134	2,635	592	564	170
Odds Ratio					
Demographics					
45 to 64 Years of Age	1.01 (0.94, 1.07)	1.37* ↑ (1.02, 1.84)	1.08 (0.60, 8.66)	2.17* ↑ (1.05, 4.47)	1.78 (0.51, 6.21)
Female	2.44† ↑ (0.61, 0.74)	2.12† ↑ (1.66, 2.70)	1.54 (0.95, 2.52)	1.67 (0.92, 3.03)	2.02 (0.79, 5.15)
Not married	0.96 (0.90, 1.02)	0.78 (0.60, 1.02)	0.70 (0.40, 1.22)	0.93 (0.48, 1.80)	1.15 (0.40, 3.33)
Education					
High school	0.67† ↓ (0.61, 0.74)	1.10 (0.73, 1.65)	1.13 (0.47, 2.70)	1.33 (0.46, 3.90)	0.89 (0.13, 6.00)
High school diploma	0.77† ↓ (0.72, 0.82)	0.94 (0.71, 1.25)	1.22 (0.65, 2.27)	1.12 (0.54, 2.31)	0.55 (0.17, 1.76)
Not U.S. born	0.92 (0.81, 1.05)	0.87 (0.63, 1.22)	0.60 (0.29, 1.24)	0.95 (0.46, 1.97)	2.33 (0.50, 10.87)

Socioeconomic						
Less than or Equal to 199% of Poverty Level	0.92* ↓	1.11	0.81	2.24	1.55	
	(0.85, 0.99)	(0.83, 1.47)	(0.45, 1.45)	(0.93, 5.38)	(0.53, 4.53)	
Lives in Non-Working Family	1.41 † ↑	1.20	1.10	0.68	2.51	
	(1.29, 1.53)	(0.91, 1.59)	(0.66, 2.03)	(0.33, 1.39)	(0.81, 7.77)	
Uninsured	0.55 † ↓	0.58 † ↓	0.74	1.11	0.32 † ↓	
	(0.51, 0.60)	(0.44, 0.79)	(0.40, 1.39)	(0.43, 2.83)	(0.11, 0.87)	
Health						
Fair or Poor Health	2.15 † ↑	3.17 † ↑	11.28* ↑	4.13	6.62	
	(1.84, 2.50)	(1.51, 6.66)	(1.04, 122.45)	(0.33, 51.34)	(0.54, 80.53)	
Had One or More Days in Bed Last Year	3.18 † ↑	3.73 † ↑	5.99 † ↑	5.30 † ↑	4.01 † ↑	
	(2.97, 3.4)	(2.75, 5.04)	(2.80, 12.83)	(2.28, 12.32)	(1.30, 12.39)	
Access						
No usual source of care	0.28 † ↓	0.34 † ↓	0.39 † ↓	0.24 † ↓	0.33 † ↓	
	(0.26, 0.30)	(0.26, 0.45)	(0.22, 0.70)	(0.11, 0.55)	(0.12, 0.94)	

Note: Confidence intervals of odds ratios are presented in parenthesis. The arrows are intended to visually identify the direction of the coefficients.

† Total AAPI population includes other AAPI subgroups including Japanese, Vietnamese, Asian Indians, and Pacific Islanders.

* p<0.05, † p<0.001

Source: Authors' analysis of 1996 and 1996 National Health Interview Surveys.

(Table 2). No other predictors affected doctor visits of Chinese. Predictors of a doctor visit in the past two years for Filipinos included increased probability with older age (similar to AAPIs), and a day in bed last year (similar to AAPIs and whites), and a decreased probability with no usual source of care (similar to AAPIs and whites). Filipinos' access to a doctor, unlike AAPIs and whites, did not significantly vary by other predictors. Among Koreans and similar to AAPIs and whites, the probability of having a doctor visit in the last two years was higher with a bed-day last year and lower with being uninsured and having no usual source of care.

Discussion

Population-based studies of disparities in access to care are particularly important in addressing the disparities in health of understudied AAPI populations. Using special data years of the NHIS, for the three socioeconomically similar groups and the larger segments of the AAPI population, aggregate AAPI analysis still masks the unique risk *and* protective factors for each group. Our results support Takeuchi and Hong's call for an AAPI health research agenda that measures the historical (for example how well each group can navigate a system that may or may not be comparable to home country healthcare systems) and cultural context (such as the availability of interpreters and bilingual providers) that shapes the behavior and treatment of specific ethnic groups.

The NHIS' exclusion of monolingual Asian individuals limited our ability to examine the impact of a number of predictors of access such as acculturation or limited English proficiency for AAPI populations. This exclusion had the likely effect of underestimating the disparities in access for AAPIs assessed in these analyses, since monolingual populations are likely to face the most barriers in access to healthcare. The absence of potentially significant cultural factors, such as preferences for alternative and complementary medicine and providers are another limitation. These along with immigration circumstances may overrepresent the importance of existing predictors of access in the models. The absence of data on year of immigration and language preferences are also limitations in understanding potential underlying reasons for group differences. Nevertheless, these NHIS data are important resources because a number of Asian and Pacific Islander groups

were disaggregated in public use datasets for the first time and allowed us to assess the performance of aggregated data face-to-face with ethnic-specific data. However, due to sample size limitations and underrepresentation of smaller AAPI groups, such as the Cambodian and Native Hawaiian populations in national population-based surveys, estimates of health and healthcare access of AAPIs continue to be incomplete and unavailable.

Implications for future of AAPI data and research

The commonly held criticism of “bad” AAPI data is *aggregation*. But the root cause of aggregation is small samples. In a population-representative sample, low frequency groups inevitably are rarely represented. Oversampling would then be the only solution. Although expensive probability-based oversampling methods are preferred, alternative recruitment strategies, such as surname-list sampling, may be a viable, more cost-effective strategy. Surname-list strategies have been employed to oversample Korean, Vietnamese, Cambodian, Japanese, and South Asian households only in CHIS 2001. Indeed, a study comparing the demographic, health, healthcare utilization, and access measures in the CHIS 2001 found that key healthcare measures, such as having a usual source of care, were very similar between the random sample and the surname-list sample (Ponce and Gatchell, 2006). Focused geographical sampling of clusters of areas with a high proportion of a targeted ethnic groups is another cost-saving option compared to probability samples. After decades of advocacy efforts to encourage an Asian oversample of NHIS, progress has recently been made nationally: in the 2006 survey year, the NHIS for the first time implemented geographic oversampling of Asian households, as has been done with black and Hispanic households in the NHIS¹. This innovation in its sampling design should improve the precision of estimates of the larger Asian groups, but may still leave out rarer groups who do not reside in the selected geographical clusters sampled. Thus consideration of alternative sampling such as surname lists for smaller groups that we know little about, such as the Cambodian, Thai, Lao, Hmong and Mien populations, and the Native Hawaiian, Samoan, Tongan, Guamanian and Marshallese Island groups should be considered, if not for every round of the NHIS, but for special supplements in designated years.

Despite its progress in sampling, the NHIS is still only of-

ficially conducted in English and in Spanish. Ensuring translated survey instruments in several Asian languages would raise the representative quality of this survey in a diverse population, following the example of the multilingual California Health Interview Survey (Ponce et al., 2004). As populations become more diverse, the cost of translation, cultural adaptation, and multilanguage administration of a survey is no longer prohibitively expensive especially given the quality gains in representation.

Lastly, assuming all efforts have been made to increase the sample size of as many AAPI groups as possible, coupled with sound confidentiality and privacy policies, public use data broken down by different AAPI ethnic groups should be made available. There is no shortage of scholars, policymakers, and advocates who are keen to explore the unanswered questions in health and health-care access of specific ethnic groups. Since the initial release of the CHIS 2001 public-use data, a “pent-up” demand phenomenon has been observed with the number of publications, conference presentations and collaborations generated from the CHIS data. This consumption of the CHIS data has quickly filled the void that Andersen and Harada noted a decade earlier (Andersen et al., 1995).

Knowing more rather than less about specific AAPI subgroups therefore hinges on policies in state and national data collection. The quality of AAPI ethnic-specific data needs to expand beyond California and Hawai‘i. In tandem with improvements in the NHIS, other state data collection systems with a large AAPI population should invest in oversampling and in-language survey efforts such as has been done in California. We also encourage the continued oversampling of Asians in the NHIS, and recommend formulating an oversampling strategy for the Pacific Islander population. While cost-effectiveness is surely a consideration, a population’s increase by nearly 50 percent from 1990 to 2000, from 3.9 million to 6.9 million (Barnes and Bennett, 2000) should warrant at least a commensurate gain in health information over that same decade. Still, a recent review article concluded that “significant data gaps remain” for baseline information on AAPIs needed to monitor the progress of Healthy People 2010 (Ghosh, 2003). Much progress still has to be made in ethnic-specific health data, but unlike twenty years ago, at least three notable public health datasets have proved to be worthy investments and tangible models for advancing AAPI health.

References

- Andersen, R., N. Harada, V. Chiu, and T. Makinodan. 1995. "Application of the Behavioral Model to Health Studies of Asian and Pacific Islander Americans." *Asian American Pacific Islander Journal of Health* 3(2): 128-141.
- Andersen, R. M. 1995. "Revisiting the Behavioral Model and Access to Medical Care: Does it Matter?" *Journal of Health Social Behavior* 36(1): 1-10.
- Barnes, J. S. and C. E. Bennett. 2000. "The Asian Population: 2000." Washington D.C.: U.S. Census Bureau. Available in PDF format from <http://www.census.gov/prod/2002pubs/c2kbr01-16.pdf>.
- Brown, E., V. Ojeda, R. Wyn, and R. Levan. 2000. *Racial and Ethnic Differences in Access to Health Insurance and Health Care*. Los Angeles: UCLA Center for Health Policy Research and the Henry J. Kaiser Family Foundation.
- Cho, J. and H.S. Juon. 2006. "Assessing Overweight and Obesity Risk among Korean Americans in California using World Health Organization Body Mass Index Criteria for Asians." *Preventing Chronic Disease* 3(3): A79.
- Frisbie, W. P., Y. Cho, and R. A. Hummer. 2001. "Immigration and the Health of Asian and Pacific Islander Adults in the United States." *American Journal of Epidemiology* 153(4): 372-380.
- Ghosh, C. 2003. "Healthy People 2010 and Asian Americans/Pacific Islanders: Defining a Baseline of Information." *American Journal of Public Health* 93(12): 2093-2098.
- Harrigan, R., N. Mbabuiki, J. T. Efirid, D. Easa, T. Shintani, Z. Hammatt, J. Perez, and T. S. Shomaker. 2006. "Use of Provider Delivered Complementary and Alternative Therapies in Hawai'i: Results of the Hawai'i Health Survey." *Hawaii Medical Journal* 65(5): 130-132, 134-139, 151.
- Harrison, G. G., M. Kagawa-Singer, S. B. Foerster, H. Lee, L. Pham Kim, T.U. Nguyen, A. Fernandez-Ami, V. Quinn, and D.G. Bal. 2005. "Seizing the Moment: California's Opportunity to Prevent Nutrition-related Health Disparities in Low-income Asian American Population." *Cancer* 104(12 Suppl): 2962-2968.
- Ichiho H. M. 2004. "Tobacco Use Prevention and Control: Implications for Native Hawaiian Communities." *Pacific Health Dialog* 11(2): 131-138.
- Ivey, S. L., K. M. Mehta, C. L. Fyr, and A. M. Kanaya. 2006. "Prevalence and Correlates of Cardiovascular Risk Factors in South Asians: Population-based Data from Two California Surveys." *Ethnicity and Disease* 16(4): 886-893.
- Johnson, D. B., N. Oyama, L. LeMarchand, and L. Wilkens. 2004. "Native Hawaiians Mortality, Morbidity, and Lifestyle: Comparing Data from 1982, 1990, and 2000." *Pacific Health Dialog* 11(2): 120-130.
- Lin-Fu, J.S. 1988. "Population Characteristics and Health Care Needs of Asian Pacific Americans." *Public Health Rep* 103(1): 18-27.
- Kagawa-Singer, M. and N. Pourat. 2000. "Asian American and Pacific Islander Breast and Cervical Carcinoma Screening Rates and Healthy

- People 2000 Objectives." *Cancer* 89(3): 696-705.
- Kandula, N. R. and D. S. Lauderdale. 2005. "Leisure Time, Non-leisure Time, and Occupational Physical Activity in Asian Americans." *Annals of Epidemiology* 15(4): 257-265.
- Kandula, N. R., M. Wen, E. A. Jacobs, and D. S. Lauderdale. 2006. "Low Rates of Colorectal, Cervical, and Breast Cancer Screening in Asian Americans Compared with Non-Hispanic Whites: Cultural Influences or Access to Care?" *Cancer* 107(1): 184-192.
- Kuo, J. and K. Porter. 1998. "Health Status of Asian Americans: United States, 1992-1994." *Advance Data* (298): 1-16.
- Maxwell, A. E., C. A. Bernaards, and W. J. McCarthy. 2005. "Smoking Prevalence and Correlates among Chinese- and Filipino-American Adults: Findings from the 2001 California Health Interview Survey." *Preventive Medicine* 41(2): 693-699.
- Mays, V., S. Cochran, and N. Ponce. 2004. "Thinking About Race and Ethnicity in Population-Based Studies of Health." Pp. 79-100 in *Race & Research, Perspectives on Minority Participation in Health Studies*. ed. G. M. Beech. Washington DC: American Public Health Association.
- Ong, P. and E. Ong. 2002. *Comparison of Census Data for Asians and Pacific Islanders in California and Other Parts of the U.S.* Rockville: The National Cancer Institute.
- Ponce, N. and M. Gatchell. 2006. "Singhs, Watanabes, Parks and Nguyens: A Comparison of Surname-list Samples to Probability Samples Using the California Health Interview Survey, 2001." *AAPI Nexus* 4(1): 61-79.
- Ponce, N. A., N. Chawla, S. H. Babey, M. S. Gatchell, D. A. Etzioni, B. A. Spencer, E. R. Brown, and N. Breen. 2006. "Is There a Language Divide in Pap Test Use?" *Medical Care* 44(11): 998-1004.
- Ponce, N. A., S. A. Lavarreda, W. Yen, E. R. Brown, C. DiSogra, and D. Satter. 2004. "Translation Methodology in the California Health Interview Survey: Challenges in Language Translation for a Major Survey." *Public Health Reports* 119: 1-18.
- Takeuchi, D. and S. Hong. 2006. "Glancing Back, Looking Forward." *AAPI Nexus* 4(1): 53-60.
- Tang, H., R. Shimizu, and M. S. Chen. 2005. "English Language Proficiency and Smoking Prevalence among California's Asian Americans." *Cancer* 104(12 Suppl): 2982-2988.
- Tanjasiri, S. P., S. P. Wallace, and K. Shibata. 1995. "Picture Imperfect: Hidden Problems among Asian Pacific Islander Elderly." *Gerontologist* 35(6): 753-760.
- Wong, S. T., G. Gildengorin, T. Nguyen, and J. Mock. 2005. "Disparities in Colorectal Cancer Screening Rates among Asian Americans and Non-Latino whites." *Cancer* 104(12 Suppl): 2940-2947.
- Yu, S. M., G. R. Alexander, R. Schwalberg, and M. D. Kogan. 2001. "Prenatal Care Use among Selected Asian American Groups." *American Journal of Public Health* 91(11): 1865-1868.

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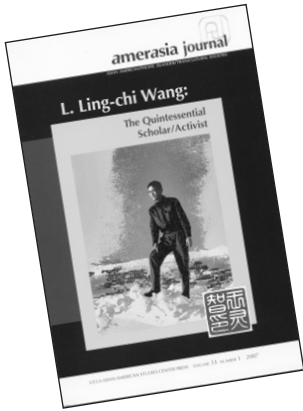
Notes

1. National Center for Health Statistics. National Health Interview Survey. ONLINE. 2007. Census for Disease Control. Available: <http://www.cdc.gov/nchs/about/major/nhis/rhoi/faq.htm> [2 Feb. 2007].

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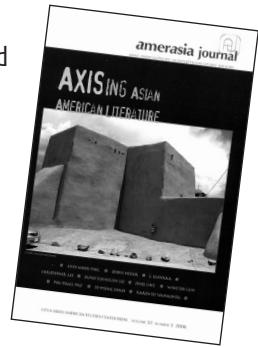


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